

**SHIFTS IN SOCIETAL PERCEPTION OF MENTAL RETARDATION  
CONCURRENT WITH SOCIAL, ECONOMIC AND POLITICAL CHANGE.**

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Abstract

This thesis assesses shifts in societal perceptions of mental retardation in South Africa from the mid-nineteenth century to the 1990s and investigates the influence of political, economic and social change on such perceptions. In order to assess the subjective nature of perceptions, evidence appertaining to legislation, policy changes and facilities provided for persons with mental retardation was sought in historical records. Relevant acts of legislation and reports of governmentally appointed commissions in the field of mental health are examined for evidence of prevailing trends. The study commences with an overview of the provision made for so-called lunatics in the early years of the Cape Colony and, because of the strong influence of British medical practitioners during the period of British rule, a comparative study of the English asylum system is included.

The onset of institutionalisation in South Africa during the final quarter of the nineteenth century is examined and the standard of accommodation is discussed. This includes references to the differing criteria for any race other than white. Allegations of constant overcrowding investigated by reference to tables of statistics, wherever available. Document analysis reveals that prior to World War I little mention was made of provision for children with mental retardation. Records reveal that during the Depression which followed in the aftermath of the war, attention was focused on feeble-mindedness among the progeny of the poor whites. Investigations disclosed that the children from this social class were alleged to be morally as well as mentally defective. The introduction and application of intelligence testing in South Africa is considered, and in particular the role this played in creating the perception of allegedly inferior intelligence in certain race groups. The special educational and training facilities

introduced for the various race groups are also discussed.

The eugenics movement, particularly in relation to the allegedly feeble-minded, is considered. The thesis concludes with an examination of accommodation and amenities available for persons the mental retardation, both children and adults, in post-apartheid South Africa, and the legal provision afforded them in the new constitution. The conclusions substantiated the notion that societal perceptions of mental retardation do vary during periods of social, economic and political change.



This thesis is my own original work. Where  
reference has been made to the work of other  
writers, their contribution has been acknowledged.

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## Chapter I

### Introduction

#### Coverage of the Scope of this Study

"...These children will never become part of a productive workforce, therefore we can no longer afford to provide a school for them. In our present economic climate the money available must be spent on normal children who will one day have the skills to offer in the marketplace."

Transcript from a speech by Dr.P.H.du Preez, Director: Schools for Specialised Education, announcing the closure of Saamstap School at the Midlands (Umgeni) Institute, Natal, November 1992. (This incident is the subject of Appendix 1)

It was this speech which alerted the writer to the extent to which the decline in the national economy was affecting children with moderate to severe mental handicap. Ordinary schools were experiencing reductions in staff, but these children were being deprived of the education which should have been their's by right:

"The mentally retarded person has the right to proper medical care and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential."

United Nations Declaration on the Rights of  
Mentally Handicapped Persons, 1971

The speech by Dr. du Preez is also a contradiction of the South African Education Affairs Act No. 70 of 1988 which entitles all handicapped children between the ages of six and twenty-one years to a form of specialised education appropriate to their needs.

From this incident there emanated a personal concern that these children, already labouring under a social stigma, were now to be devalued even further. Weighed in the balance against other children, they were perceived as worthless by a representative of a society whose sole criteria appeared to be that they should "one day have the skills to offer in the marketplace."

If the statement by Dr. du Preez epitomised society's perception of the mentally retarded, then South African society should re-examine its ideologies and sense of values.

The closure of Saamstap School was dictated by an economic recession and this posited the question of how many times a national crisis, be it financial, political or social, had occasioned similar experiences resulting in further disadvantage to the mentally retarded.

It was therefore decided that this issue should be researched. South Africa is a rich field in which to explore the parameters of inequality. If ordinary non-Europeans were disadvantaged by the policies of apartheid, then the mentally handicapped members of those communities were likely to be doubly burdened. Although racial issues do not predominate in this work they will be discussed in a subsequent chapter.

Foster (1990) describes the "discovery" of mental defectives in South Africa as occurring between 1916 and the early 1930s. Prior to the Mental Disorders Act No. 38 of 1916 mental handicap in this country was treated merely as a sub-category of mental disorder. Act No. 38 was the first formal attempt to define the categories of mental disorder, mental infirmity, epilepsy and moral imbecility.

The terminology used in 1916 would today be regarded as socially offensive. Using legally defined terms, Act No. 38 refers to persons in the sub-categorical divisions of mental deficiency as "idiots"; "imbeciles"; "moral imbeciles" and "feeble-minded".

In Europe and in the United States terminology in the field of mental health has undergone considerable change during the past fifty years. In an endeavour to create more sensitive and more socially acceptable "labels", terminology has moved through "mentally handicapped"; "with learning difficulties"; "scholastically disadvantaged" and "academically challenged".

While the appropriateness of some of these terms might be challenged, it is suggested that the perceived need to develop a more satisfactory title indicates an awareness of the discriminatory nature of labelling.

In South Africa the changes have been few. Officially accepted terminology continued to be "mentally retarded" or "mentally handicapped" until the mid-nineties.

In March 1996 the Integrated National Disability Strategy of the Government of National Unity published Government Gazette No. 17038 as a discussion document for public comment. Section 2.3 of this document recommends the term "persons with mental handicap" should replace the term "retarded". It is noted that such a change is only a recommendation, it has not yet been legally accepted.

The central issue throughout this study is the extent to which South African society perceives the needs of mentally handicapped persons and how adequately these needs are being met. In order to understand how present-day perceptions were formed it was deemed necessary to provide an historical account of the provision made for persons with mental handicap throughout South Africa's history.

Historically the field of mental retardation throughout the world chronicles an account of atrocities, abuse and neglect seldom endured by any other social group, with the exception of the Jews.

Skultans (1979) asserts that the Spartans killed their defectives and that Martin Luther advocated putting them to death on the grounds that the devil dwelt in them. Adolf Hitler strove to exterminate them in an effort to achieve racial purity.



For centuries those regarded as insane were chained to prison walls, whipped and starved into submission. During the eighteenth century they were tormented in order to provide entertainment for the English middle-classes on their Sunday afternoon outings. A century later, when the medical profession dictated that insanity was a curable condition, the insane were subjected to horrendous practices in the guise of treatment. Skultans (1979)

Complacently society declares that such actions would no longer be condoned, yet periodically acts of inhumanity come to light which substantiate the assertion that the mentally retarded continue to be classed as second-class citizens or worse.

In September 1993 the B.B.C. (London) reported mentally handicapped children living in sub-human conditions in an institution in Berat, Albania:

"...Barely clothed, filthy, covered with sores and flies, they lie on urine-soaked mattresses or creep along the floors to follow shafts of sunlight."

Bill Hamilton, B.B.C. Breakfast News,  
12th September 1993

Two months later the British press reported patients, including severely retarded children and adults, being abandoned and left to fend for themselves without food, heating or clothing, when staff joined the exodus of civilians fleeing from Fojnica in war-torn Bosnia.

The Independent, London. 15th November 1993

From Guangdong Province, China, reports recently emerged of new legislation which could have far-reaching ramifications.

"A law has been issued declaring that as from June 1st. 1995 marriages between couples likely to pass on genetic deficiencies preventing "the victim from living independently" will be banned. Pregnant women will be required by law to undergo testing and advised to abort unborn children with serious abnormalities. Included in the list of genetic deficiencies are Down's syndrome, albinism and "rabbit children", so called because of congenitally deformed mouths. Chinese officials claim the law is aimed at ensuring the health of mothers and infants, and improving the quality of the newborn population. To others the law is reminiscent of the racist eugenics policy pursued during Germany's Third Reich."

The Sunday Times, London. 5th February 1995

Nor is South Africa blameless. On 31st March 1995 the Daily News, Durban, exposed the plight of eighty severely disabled and mentally handicapped black children still living in appalling conditions at the "practically abandoned" St. Anne Hospital at Umlazi, Natal, eight months after their situation had originally been publicised by the newspaper. According to the Medical Officer, Dr.Mokoape, the situation is worsening daily.

"...It is like a medieval horror chamber, the children, between eight and eighteen, are living in unimaginable conditions. Cold food is sporadically delivered and laundering of the bedding has not been done since February. The children sleep in open dormitories, exposed to the elements, with insufficient blankets."

The Daily News, Durban. 31st March 1995

The "crime" of all these victims is that they are perceived to be "different".

The concept of mental retardation accepted by the writer is that laid down in the Diagnostic and Statistical Manual of Mental Disorders 1994 46 (American Psychiatric Association):

"The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home-living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, safety and health. (Criterion B) The onset must occur before the age of 18 years. (Criterion C)"

The social and economic problems obtaining in South Africa at the present time can in no way be compared with those of First World nations. During the past few years social workers in both Natal and the Northern Transvaal have been making contact for the first time with mentally retarded children in rural areas. The number of such children greatly exceeds the expected figure and, as yet, the social workers have only touched the tip of the iceberg.

Despite many problems being unique to South Africa, it was decided that some mention of comparative work would be useful, not as a contrast of the amenities available, but of the prevailing attitudes towards the perceived needs of the mentally retarded. Annual visits to England, coupled with a close association with those working in the field of mental health, enable the writer to observe first-hand the changes taking place in that country. Visits to the United States, although occurring less frequently, also enable the writer to engage in personal interviews with mental health workers in that country.

Any study of this length has to place a limit on the period under discussion. Preliminary research revealed that the immediate post-Union years in South Africa witnessed a significant upsurge in official documentation concerning mental health. Whether or not the recommendations contained

in this plethora of Government reports and Acts of Parliament were ever implemented is the subject for discussion in a later chapter.

Although the Act of Union in 1910 was originally judged to be a relevant point at which to begin this study, it soon became apparent that a fully comprehensive picture of provision for the allegedly insane in South Africa would only be possible if a much earlier commencement date was chosen.

The system of institutionalisation had been gaining momentum in Europe and in America throughout the nineteenth century, and South Africa, albeit a somewhat late arrival on the scene, was no exception in favouring this method of controlling the alleged lunatics. In order to achieve a fuller perspective it was felt necessary to include, early in this study, a brief overview of the pre-conceptions brought to this country by successive groups of settlers and to examine their influence in the control of lunacy in South Africa.

Historical research therefore commenced with the perusal of records appertaining to the care of the insane from the early days of the Cape Colony onwards. From such sources data was extrapolated and a paradigmatic framework gradually emerged. These paradigms were then traced through successive Acts of Parliament, Parliamentary debates as reported in Hansard, reports and recommendations of special commissions and the records of mental health societies.

Although such sources provided the essential historical background it was noted that they represented only the official findings of collective groups. Whilst "society" is a collective term, every society is comprised of individuals, and personal accounts of attitudes towards the insane in the early Cape Colony, although sought, remained virtually untraceable.

Repeatedly throughout the period of research one word predominated from the mid-nineteenth century onwards. That word was "control". Medical practitioners advocated it; wealthy philanthropists financed asylums to ensure it; society accepted it. Control was perceived as the only rational method of dominating the insane, so alleged lunatics were controlled by whatever means were considered necessary. Therefore the perceived need to control allegedly insane persons will be the central issue throughout this thesis.

When writing of mental retardation in an historical context it appeared appropriate to use the generalisations of "lunatic" and "insane" where such terms were in current use. Consequently this is the policy throughout the early chapters of this study, with changes in terminology being used once these were officially accepted.

Whilst it is realised that the name "South Africa" should technically only be used with regard to the four provinces collectively after Union in 1910, for the sake of brevity this term has been used throughout this work.

South Africa is in a period of dynamic change. The demands on financial resources are enormous. Priority is being given to housing, to the provision of services and to lowering the number of unemployed. With regard to provision for persons with mental handicap the need must be perceived before it can be redressed. It is hoped that in the course of this work such perception will be evidenced.

On 25th May 1994 a conference on "Affirmative Action and the Disabled" was held in Durban. Dr. William Roland, President of the South African Association for the Blind, called for equality for all disabled persons, whether their handicap be physical or mental. He stated that organisations must seize the opportunity to have such a clause written into the new Constitution. Roland ended with these words:

"The window of opportunity is open right now. We possibly have only a few months before the euphoria disappears and inertia sets in."

Two and a half years later the euphoria has disappeared. This study will conclude by discussing whether inertia has set in.

With this quotation in mind it was decided to set the promulgation of the new Constitution as the closing date for this study.

## Chapter II

### Changing Perceptions in Fiction;

#### From Lunatics in Eighteenth and Nineteenth Century Literature

#### to Characters with Learning Difficulties in Twentieth Century

### Films and Television

Descriptions of the horrendous conditions in the early asylums of Europe are numerous. In particular the present writer will refer to works by Scull (1987) and Skultans (1975) in due course. The purpose of this study is to research societal perceptions and, as stated in the previous chapter, "society" is a collective noun. It is not surprising that most recorded perceptions were those of government, governmentally commissioned groups, or societies concerned with mental health.

Although attempts were made to ascertain personal viewpoints in an historical context this was not possible. No individual perceptions of lunacy could be traced during the historical research.

An abstract conception is difficult to quantify, it is much simpler to evaluate statistics and official records, yet the purpose of this study is to attempt an evaluation of the emotive issue of society's perception of the retarded.



Frequently one can only interpolate. If London society in the days of the Regency enjoyed Sunday outings to taunt and tease the insane in Bedlam then one must deduce that they perceived lunatics in much the same light as performing animals.

In the absence of recorded individual perceptions it was considered that the representation of sub-normal characters in fiction might prove an interesting barometer of changing attitudes. With this in mind a short selection was taken from classical literature and comparisons made with similar representations of fictional characters appearing in recent films and television programmes.

It may perhaps be considered unfair to compare the novel in the nineteenth century with the entertainment offered by television and cinemas of today. However, a study of nineteenth century literature reveals a popularity of the novel, commensurate with ever-increasing literacy, which would render such a comparison reasonably appropriate.

Typical of the Romantic poets, William Wordsworth presented his Idiot Boy (Lyrical Ballads, 1798) in a setting of rural domesticity. The imagery is one of maternal love surrounding the title character. This effect of the boy encircled by love is heightened when the moonlight creates a nimbus around his head, thus suggesting an aura of sanctity. Such a concept might be seen as a re-affirmation of a medieval view that the simple-minded were God's children. William Langland, (Fourteenth century poet) uses the phrase,

"God's boys...jesters of Jesus."

In contrast to the romanticism of Wordsworth, the simpletons created by Charles Dickens inhabit a world which is often harsh and cruel. Passionately opposed to the newly created and rapidly expanding system of institutionalisation Dickens frequently used his characters for the purpose of propaganda.

The feeble-minded Smike (Nicholas Nickleby, 1838/9), while not confined to an asylum, has spent much of his short life in a school which bore all the worst hallmarks of institutionalism. His condition has been exacerbated by starvation, constant ill-treatment and by the permanent state of terror to which he has been reduced.

Dickens was well aware that the mentally defective can often appear unattractive, thus he does not attempt to glamourise his character. This simple-minded youth of "some eighteen or nineteen years" is presented as a grotesque figure, garbed in the only clothes he possesses, those he wore on his admission to the school some seven or eight years previously. A master of caricature, Dickens immediately establishes sympathy between his readers and this boy, grotesque though he appears. We see a child inside the body of an adult, the imagery of retardation could hardly have been better.

Dickens advocated keeping lunatics within the community and to emphasise this point he transports Smike out of the institution into a caring environment and comments vividly on the improvement in the boy's condition.

This theme continues with Dickens' portrayal of Mr. Dick (David Copperfield, 1850). In the list of characters contained in a preface to the novel Dickens describes Mr. Dick as "a harmless lunatic". Later he has Mr. Dick describe himself as "simple", thus his readers are in no doubt about the mental condition of this character. Gentle and genial, he has been rescued from his brother "who would have shut him up for life in some private asylum-place." In an age when mental defectives were increasingly becoming controlled by those in authority, the relationship Dickens establishes between Mr. Dick and his benefactress appears unique. It is the constant endeavour of Miss Trotwood to imbue this simple man with a sense of self-worth. A rare concept in the mid-nineteenth century.

If Dickens accredited his mentally defective characters with the ability to assimilate into the community, the views of Charlotte Bronte were widely disparate. Her "madwoman" (Jane Eyre, 1847) must be guarded day and night, locked in an isolated room, rarely allowed out. Bronte's imagery is one of a human being reduced to the basest of animal instincts. Mrs. Rochester's room is "a den of filth"; she lives as "a wild beast". Her ultimate escape results in death and destruction. Purported to have inherited insanity from her mother and obviously violent, she is an object to be feared and hated. Bronte wastes no pity on Mrs. Rochester, her readers are intended to perceive a madwoman with loathing and dread.

The present writer would suggest that representations of madness such as this were likely to have had considerable influence over public perception of lunacy in the mid-nineteenth century.

Today our perceptions are not infrequently shaped by the media and the past decade has witnessed meaningful change in the representation of mental retardation in the entertainment industry. It has been mentioned that Charles Dickens manipulated his readers by using his characters as propaganda. This assertion is no less true today. The trend in Europe and the United States is towards the closure of large mental institutions and the integration of mentally retarded persons, even those in severe or profound categories, into the community. Recent television series have undoubtedly played a major role in establishing the validity of this theory. They aim to show that persons with mental handicap need not be institutionalised, but can remain within normal communities and make worthwhile contributions.

Perhaps the most popular example of this was that of Benny, a mentally handicapped character in the television series L.A. Law. Adrift in the community following the death of his mother, Benny is given employment in a menial capacity by a firm of highly successful attorneys. In spite of some initial scepticism Benny is presented as functioning adequately. Benny is portrayed as being accepted by the staff and integrating well. On analysis one realises that he is not treated as normal, always there have to be allowances for his

limitations, in fact Benny is "different" and will never be accepted on an equal footing. The present writer sees this as an important contribution by the script-writers of the series to the assimilation of persons with mental handicap into the community. If Benny had been portrayed as becoming socially acceptable to his affluent colleagues, it is suggested that a disservice would have been done to those persons with mental handicap trying to find a niche in society. Considerable change in public perception must come about before total social acceptance is possible, and it is therefore suggested that it would be wrong of the media to portray such persons as being readily accepted into every facet of the community at the present time.

Later episodes allowed Benny to marry his mentally handicapped girl friend. Here the script writers moved into a controversial area, whether marriage between persons with mental handicap should be condoned. Unfortunately the series ended before too many of the problems facing the couple could be explored.

A major breakthrough in the portrayal of retardation was to cast a high-functioning Down syndrome boy in the fictional role of a corresponding character in a television series. Dubbed into Afrikaans in South Africa, the series was known as *More is nog 'n Dag*, with Chris Burke playing the pivotal role of the boy. Here the appeal to the public is twofold.

Through the story-line they can follow the difficulties of a fictional family with a handicapped child, yet at the same time they are witnesses to the triumph of a factual boy overcoming a similar handicap.

In the film world it has been seen as expedient to employ star names in the representation of retardates. Dustin Hoffman in Rainman and, more recently, Tom Hanks in Forrest Gump, emphasise this point. The Hoffman character worked as a garbage collector in order to help his normal brother through college. His colleagues treated him with a mixture of kindly tolerance and malicious teasing. Once again, they do not regard him as an equal, he is "different".

This point is emphasised even more strongly in Forrest Gump. He becomes a war hero and a millionaire, yet he is never accepted as normal. Even casual acquaintances view him as "different". Unfortunately few are prepared to accept him for his own worth.

If the entertainment industry is intent on making the point that integration is to be the solution for the future of the mentally handicapped, then it is hoped that such exposure will help to educate communities in the acceptance of those who are perceived to be "different".

It will be noted that all the above mentioned fictional characters in poetry, literature, films or television are English-speaking Caucasians. In an effort to re-dress the

balance and in order to achieve greater pertinence to South Africa every effort was made to locate comparable figures in the literature of the Afrikaans, Indian and Zulu communities. In this endeavour assistance was provided by the following:

Prof. Colin Gardner, Department of English,  
University of Natal, Pietermaritzburg.

Dr. Adrian Koopman, Department of Zulu,  
University of Natal, Pietermaritzburg.

Members of the Afrikaans en Nederlands Dept.  
University of Natal, Pietermaritzburg.

Dr. Tina Jonker, Head of Durban Mental Health  
Society.

Dr. Ram Naidoo, Principal of Belvedere Primary School  
Chatsworth, Durban.

Mrs. Maud Nkabinde, Principal of Ekukhanyeni School,  
Imbali, Pietermaritzburg.

With one exception no reference to mentally retarded characters could be traced in the literature of these communities.

The exception was *Ampie der Kind* by Jochem van Bruggen (1973) and Dr. Jonker affirmed that this character could more accurately be termed culturally, rather than mentally, retarded.

One significant factor emerged from discussions with the aforementioned groups. Until recently the Indian and African

communities have kept their mentally handicapped members hidden from view through a sense of shame, and the Afrikaans community retained a similar attitude far longer than their English-speaking counterparts. It was not possible to define a specific turning point, these communities contained too large a degree of variability, but while attitudes have changed within the urban environments, the practice of keeping sub-normal children hidden is still rife in certain rural areas. (This is an area for discussion in a later chapter.) If shame forced these groups to shield their mentally handicapped members from public gaze it is perhaps understandable that they should choose not to acknowledge such handicaps, either in literature if the community was literate, or in oral story-telling in an illiterate populace.

The mentally handicapped characters in the twentieth century portrayals are all assimilated moderately well into the community. The examples were taken at random, but in every case the film or television programme was a product of the United States. In a nation where total integration of the "scholastically disadvantaged" into the community is being advocated it may be politic for the media to portray fictional cases of the successful assimilation. Unfortunately personal conversations with American teachers and social workers concerned in the field of mental health lead the writer to believe that in many cases factual results are less satisfactory than those portrayed on the screen. It would appear that Charles Dickens was not the only person to use his characters for the purpose of propaganda.

This brief overview of the portrayal of mental handicap in literature was included as an example of the changes in the perceptions of writers over the past two hundred years. The following chapter will present a more factual historical



account and will trace the earliest provision for lunatics in the Cape Colony and present a comparative account of the British Asylum system.

### Chapter III

#### Historical Background

##### Part 1: Provision for Lunatics in the Cape Colony 1653 - 1891

##### Part 11: Comparative Survey of the Onset of the British Asylum System

The purpose of this chapter is to explore the perception of lunacy in the Cape Colony commencing with the earliest traceable references dating from the eighteenth century.

The movement towards custodial confinement will be traced, with emphasis on the evolution of standards in respect of accommodation and treatment of lunatics during the nineteenth century.

Throughout the present research two themes have been in constant evidence. Firstly, the perceived necessity of imposing control on those described as insane, and secondly, the role of second-class citizens to which they have been relegated. This chapter will investigate the origins of these attitudes in the South African context.

As stated in Chapter 1 it was considered suitable to use the terminology regarded as acceptable during the period under discussion. Therefore when the terms "lunacy" or "insanity" are used in the present chapter and in the chapter which immediately follows, it is understood that these refer to both the mentally ill and mentally retarded.

It is the aim of this chapter to identify, through such records as are available, any significant themes which may be traced as subsequent events develop. It is theorised that perceptions of lunacy, laid down at an early stage in South Africa's emergence towards an industrialised, capitalist society, would point the direction to future trends.

This chapter will be divided into two parts, with subdivisions where appropriate.

#### Provision for Lunatics in the Cape Colony 1653-1891

The lack of documentation regarding the attitude of society towards those delineated as insane in the Cape Colony during Dutch occupation precludes a clear understanding of the position. It was therefore decided that an assessment of the perception prevailing at that time might best be determined through an examination of the facilities which were provided for the lunatics in the Cape Colony during the eighteenth century. Here again traceable records are sparse.

Part I (a) will begin with the earliest recorded mention of accommodation for lunatics in the Cape Colony in the eighteenth century, under Dutch rule.

Part I (b) will follow this with a description of the provisions made for lunatics in South Africa in the nineteenth century, under British rule.

Part II (a) will discuss the growth of the British Asylum system. (Included because of the likely influence on British medical practitioners arriving in the Cape Colony).

Part II (b) will examine the alleged reasons for the increase in the numbers of insane persons in England during the first half of the nineteenth century. (Included for later comparison with a comparable situation in South Africa.)

### Part I (a)

#### Provision for Lunatics under Dutch Rule - Seventeen and Eighteenth Centuries

Minde (1947a), Burrows (1958) and Foster (1990) all assert that a dominant factor emerging from a study of the Cape Colony in the early period is that lunatics were included along with criminals, political undesirables and the chronic sick, in the general category of social outcasts. While one assumes the above mentioned writers are referring to the physical confinement of lunatics, it is not clear whether they are also referring to the public concept of lunatics. Either way such an assertion is an indication that, as a group, the lunatics were held in low esteem.

It will be shown later in this chapter that lunatics were housed in the same premises as the chronic sick and the lepers in at least two instances, therefore substantiating in part the above statement. In both instances the lunatics were

housed in separate wings. The only examples of lunatics being accommodated with criminals would appear to be when the lunatics were considered violent.

It should be pointed out that prior to the early years of the nineteenth century the need for control over lunatics, other than those regarded as violent, does not appear to have been a major issue in the Cape Colony. Few references to lunatics could be found in historical accounts of early Cape Town. Those available are quoted below. Perhaps one may deduce that lunatics, particularly those whose symptoms were mild, were assimilated into this pioneering community without too much difficulty. It will later be shown that it is only when a community becomes more sophisticated and moves towards an industrialised and commercialised society that the non-productive members of that community come to be seen as a problem.

The difficulty in attempting to ascertain the numbers of lunatics in the Cape Colony, as elsewhere, during both the eighteenth and nineteenth centuries is exacerbated by the fact that the term "lunacy" covered a wide spectrum of disorders. No differentiation was apparently made between the mentally retarded and those suffering from mental illness. Thus one had what we would now call alcoholics, epileptics, schizophrenics and depressives included with all grades of mental retardates under the title "lunatics".

The earliest official attempt to define categories of insanity was the Cape Lunacy Act No. 35 of 1891 which drew distinctions between "criminal" lunatics, "dangerous" and "ordinary" lunatics. However it will be noted, in a later paragraph, that as early as 1711 there is a mention of separate accommodation being erected to house lunatics considered to be violent.

Minde (1974); Kruger (1980); Burrows (1958) and Die Geskiedenis Van Die Oranje Hospitaal 1884-1986 each provide documentation on the early hospitals in the Cape Colony, although contradiction occasionally occurs in both the dating and the structural form of these institutions.

Burrows (1958), citing Kolbe's Beschryving VI p227, states that on the instructions of Van Riebeeck a temporary hospital, possibly a tented encampment, was erected in 1653, with a "Fine hospital with stone walls" replacing the original in 1656.

However Minde (1974), citing Laidler (1937) describes the 1656 structure as "...very roughly constructed of planks thatched with reeds", dating the stone-built hospital as 1699. In addition Minde (1974) records that a ward for mental patients was later added, as described in the Archives:

"It was moreover decided as a useful and orderly measure to build on to one of the wings as soon as possible a small enclosed apartment for locking up

the mad who are now and then found in the hospital and with whom at present we are embarrassed."

De Kock (1950), cited in Minde (1974) p.1271.

The centenary brochure of Oranje Hospitaal (Die Geskiedenis Van Die Oranje Hospitaal 1884 - 1986) describes the 1653 hospital in the Cape Colony as consisting of planks, bamboo and thatch, but without a reference to substantiate this information.

Despite the discrepancies it appears that the first hospital was a temporary structure, but by the end of the seventeenth century, at the latest, the Colony had a stone-built hospital.

The information relating to the admission of lunatic patients is also contentious. Burrows (1958) asserts it was a general hospital, used solely for the crews of ships putting into Cape Town harbour. Those considered too ill to complete the voyage to Europe or India were treated in the hospital and upon recovery shipped out as crew on another vessel. Thus the crew of each vessel could be replenished by recuperated men as required.

Minde (1974) confirms that the purpose of the hospital was primarily for ships' crew members, but indicates, in the printed extract quoted above, that lunatics were also admitted. One may perhaps conjecture that some of these

lunatics were seamen suffering from some form of mental illness. It will be seen in the course of this chapter that the admittance of seamen to hospitals or asylums was an on-going problem in the Cape Colony.

The document of the Oranje Hospitaal gives a more detailed, but unsubstantiated account of the presence of lunatics in the Cape hospital. It states that lunatics were housed in small outbuildings in the grounds of the main hospital, where they were cared for by their own families. Unless proved dangerous or violent, the lunatics were allowed to move around freely, but if considered dangerous they were manacled and confined to windowless rooms. Indigent lunatics having no families became the responsibility of the church who boarded them out with selected families. In extreme cases violent or dangerous lunatics were sent to the convict settlement on Robben Island.

Die Geskiedenis Van Die Oranje Hospitaal brochure 1884 - 1986

The same source also records that reports of cruelty to patients were infrequent, with severe punishments being meted out to staff found guilty. There is, of course, no mention of unreported incidents of ill-treatment.

It is not known how often co-operation between family or community and an institution occurred in caring for lunatics in the eighteenth century. No reference to this combination of controlled accommodation coupled with family obligation, could be traced in any other source.



During the eighteenth and nineteenth centuries it appears to have been the practice in Europe for the families of prisoners to be allowed to bring their meals into gaol on a regular daily basis. Dickens describes this custom in *Little Dorritt*, (1857). Presumably such a practice would relieve prison authorities of considerable expense, although there must be doubts about the ability of impoverished families to provide adequate food for prisoners, particularly if the malefactor was the sole breadwinner.

It may be that the Dutch authorities in the Cape based their form of family involvement with regard to lunatics on a similar principle.

Kruger (1980), Burrows (1958) and Minde (1974) all record that in 1711 Commissioner Van Hoorn ordered that an apartment for the mentally ill be added to the Cape Hospital, and that dangerous lunatics were to be confined there. In addition Minde (1974) reports that a house for the chief surgeon was to be erected, also adjacent to the hospital built in 1699. Thus it would appear that by 1711 dangerous lunatics were segregated from the non-violent, and that they were confined in separate accommodation.

It is understood, however, that the aforementioned facilities were provided only for servants of the Dutch East India Company and the military. Burrows (1958) declares that it is unclear whether Free Burghers were ever admitted to the Cape Hospital, run by the Company, even during the great eighteenth century epidemics, and present research bears out this statement.

Part 1(b) Provision for Lunatics under British Rule -  
the Nineteenth Century

After the establishment of British rule in 1806 records become more accessible, although conflicting accounts render certain data controversial as will be illustrated later in this chapter.

The earliest traceable primary sources with regard to lunacy after the British assumed control of the Cape Colony were The Cape Town Gazette, (July 1818), The African Court Calendar of 1823 and Parliamentary Ordinances of 1833.

The Parliamentary Ordinances were concerned only with the property of the lunatics, and not with their well-being. Given the attention paid to property in these Ordinances and those that were to follow, one might conjecture that materialism took precedence over the welfare of the lunatics.

When one considers the priorities of a settler community, perhaps such an attitude is hardly surprising.

Both the other primary sources, The Cape Town Gazette, (July 1818) and the African Court Calendar (1823), emphasise that the establishment of the first civil hospital in the Cape was of prime importance. Kruger, (1980 p.8) describes this as "Dr.Bailey's Hospital and Asylum", but this would appear to be an error. Although Bailey was the founder and first medical superintendent of this establishment it would appear that it never bore his name. In honour of the Governor the

new institution was named Somerset Hospital. It is probable that the hospital became known locally as "Dr. Bailey's" hence the misconception by Kruger. Dr. Bailey was later to open another hospital in Cape Town, but this was called the Merchant Seamen's Hospital, and there is no indication that lunatics were ever accommodated there.

Kruger, (1980) also makes reference to a patient running amok "at the hospital" and subsequently being confined in the convict colony on Robben Island. However, Kruger dates this incident as 1718, one hundred years before the opening of Somerset Hospital. It is probable this incident took place at the Cape Hospital and not at Somerset Hospital. Burrows (1959) records a similar incident occurring at the Cape Hospital in 1718, so one may assume that Kruger is in error.

The African Court Calendar (1823) contains a record of an advertisement placed by Bailey in the Cape Town Gazette to announce the opening of Somerset Hospital:

#### "Somerset Hospital

Mr. Bailey, Surgeon and Accoucheur, begs leave to inform his Friends and the Public, that having nearly completed the above Institution, under the immediate Sanction of His Excellency the Governor, he intends opening his Hospital and Lunatic Asylum on the first of August, for the reception of Merchant Seamen and the Slave Population of the

Colony, on the under-mentioned Terms, feeling fully sensible of the very great Advantage the Inhabitants of Cape Town, and more particularly those residing in the Country, must derive from an Establishment of this nature; he trusts, and confidently hopes, that he will meet with that Support, which such a very serious Undertaking requires. The hospital will be established on similar Principles with those in Europe and he begs leave to remark, that nothing shall be wanting in his Power, to render the same useful and comfortable."

Cape Town Gazette, July 1818,

Bailey lays down terms for the treatment of slaves, both as outpatients and as resident patients, but fails to mention the rates of payment for the merchant seamen. Bailey concludes the announcement:

"The Hospital and Lunatic Asylum will be open at all times to the Inhabitants of the Cape and the Country Districts; and those who may not (sic) approve of the above proposals will be at liberty to send their Slaves, or any Paupers they may think proper, by paying for their Maintenance and Lodging as per Term 1, and for their Medical Advice and Medicines, as per established Tariff of the Colony."

Cape Town Gazette July 1818.

It is suggested that a possible error has occurred in the wording of this announcement in the original printing. It appears likely that it should read, "...those who may approve of the above proposals.." and not, "... those who may not approve of the above proposals...". Although Burrows (1958) includes the disputed word when citing this announcement, this wording appears so unlikely that a repetition of the original error would appear probable.

It will be noted that Bailey declares the Hospital will be established on similar principles to those in Europe. In Part 11 of this chapter the present writer will suggest that British medical practitioners would bring with them pre-conceived ideas on the management and operation of such institutions, and it would appear that Bailey's statement would substantiate this suggestion.

Burrows (1958) infers that Somerset Hospital was the first civil hospital, the announcement in the Gazette makes no mention of admitting burghers or members of their families. It refers only to Merchant Seamen, slaves, servants, lunatics and paupers. The inference is that Somerset Hospital, at least initially, catered only for the lower strata of society. The racial structure of this group will be discussed in a later chapter. Burrows (1958) records that the hospital was also to act as a staging post for lepers en route to the leper colony at Hemel en Aarde at Caledon.

After a short period of relative prosperity Bailey was apparently in dire financial straits. In 1821 he was obliged to sell the hospital to the Burgher Senate at a considerable loss, and his belief that he would be retained as Surgeon-in-Charge was confounded when the Senate chose to appoint their own administration. Burrows (1958)

Burrows (1958) records that the original buildings were totally unsuitable for use as a hospital, and conditions did not improve under management of the Burgher Senate.

In March 1824 Dr. James Barry, Colonial Medical Inspector declared that he found:

"five of the fifteen so-called lunatics were quite sane and fit for discharge."

Cape Archives 12th. September 1833 cited in  
Burrows (1958)

Furthermore, Dr. Barry is reputed to have made the remark that the wards were as dirty as the patients, declaring

"...this Establishment certainly does not deserve to be dignified with the name of Hospital."

Cape Argus 1st. February 1870, cited in Burrows  
(1958 p.112)

If one third of the "so-called lunatics" were found to be sane on this occasion, one must question the prevalence of wrongful committal during the nineteenth century. Kruger (1980 p. 8) describes the authority for the detention of the

mentally ill at the Cape as "based on highly questionable powers". He states:

"No explicit provision apparently existed at the Cape authorising the confinement of the mentally ill, but it was accepted that this could be done under Roman-Dutch law." Kruger (1980 p.8)

According to Kruger (1980), under Roman-Dutch law the nearest male agnate was appointed as curator over the estates and possessions of the patient, with the right of confinement also being granted in respect of certain mentally ill persons. It is suggested that such legislation safeguarded the possessions of the patient rather than the patient himself. The right to detain a patient appears shrouded in ambiguity, with no mention being made of the patient's recourse to appeal. The legitimacy of confinement in the early years of the Cape Colony will be the subject of discussion in Chapter VI.

By 1830, according to Burrows (1958), Bailey had returned to Somerset Hospital and it not only became the nucleus of medical activity in the Colony, but was apparently established as an officially recognised lunatic asylum. Burrows (1958) records that the Government officially referred cases there for Dr. Bailey's attention. No mention is made of the categories into which such cases fell, but if any patients were allegedly insane this would appear to indicate that the Government recognised Somerset Hospital as an asylum. The fact that ten insane patients were apparently transported the nine hundred kilometres from Grahamstown to Somerset Hospital in 1834, would further substantiate this suggestion. Minde, cited in Burrows (1958).

By 1834 the patients at the hospital were resolved into four classes: lunatics, lepers, chronic sick and paupers, and routine medical cases. Apparently each side of the 350-foot enclosure was allocated to a different purpose. Thus the hospital provided a lunatic asylum, leper institution, pauper ward and a medical hospital all on the same premises, although it would appear, from Barry's comments, that such premises were grossly unsuitable for the purpose.

Although apparently accepted as the official lunatic asylum for the Colony, the condition of the lunatics in Somerset House was wretched and Burrows (1958) records that facilities for their proper treatment were wellnigh non-existent. It has been mentioned earlier, that the hospital served only as a clearing station for lepers en route to the colony at Hemel en Aarde. This would suggest a frequent fluctuation in the number of leper patients. According to Burrows (1958) the quarters for the lunatics became so overcrowded that cells in the leper wing were converted for their use. This point is of particular interest in the present study. At a period when leprosy was regarded as incurable and every leper was strictly segregated from the community, it appears that the alleged lunatics in Somerset Hospital were housed in cells in the leper wing. It is suggested that the only periods when Somerset Hospital was empty of lepers would be immediately following a transfer to Hemel en Aarde. It will be shown later that the leper population at the hospital appears to have been fairly regularly maintained, therefore it would appear likely that lunatics and lepers would be in adjacent cells. Under the conditions which appear to have prevailed at Somerset



Hospital, it seems likely that contact between the lepers and the lunatics housed in that wing would be inevitable. The fear of contamination by leprosy appears to have been ignored in the case of the lunatics, a fact which provides some insight into their perceived worth.

By 1837 Bailey reported thirty-eight lunatics in the hospital, a number which completely filled the asylum. This number appears to have remained constant, because records of the asylum on Robben Island show that thirty-eight lunatics were transferred there from Somerset Hospital in 1846 when this new asylum was established. This would suggest that little had been done to rectify Barry's allegation, twenty-two years earlier, that one third of the so-called lunatics were quite sane and fit for discharge. While there is always the possibility that these cases had, in fact, been discharged and their places taken by patients who were certifiably insane, reports of conditions at Somerset Hospital preclude such optimism.

Some indication of the priorities accorded to lunatics by those in authority may be gained when one discovers in the African Court Calendar of 1823 that a certain Reynand Miller, who had been appointed to Somerset Hospital as a porter, was also employed as lunatic asylum keeper. According to Minde, (1947 p.1630) Miller was dismissed in 1836 because "his alcoholic habits became so marked."

A further insight into the deplorable conditions in the asylum at Somerset Hospital may be gleaned from a quotation by the Dean of Cape Town written on the eve of the removal of the lunatics to the former convict colony on Robben Island:

" ...anything more wretched and inappropriate for its unfortunate inmates cannot be imagined than the lunatic wards (of Somerset Hospital)"

Newman (1855 p.222)

Later in this chapter the appalling conditions on Robben Island will be discussed, yet it would appear that they were regarded as an improvement on those endured at Somerset Hospital.

A theme which will occur many times throughout this study is already emerging. That is a lack of concern on the part of society for the welfare of the lunatics, even when their condition is described as deplorable. In the case of Somerset Hospital the first recorded complaint about both the conditions in which the lunatics were confined and the legitimacy of their detention was raised by Barry in 1824, yet no enquiry appears to have been instigated, nor any improvement noted.

No explicit reference to violent lunatics being housed in Somerset Hospital could be traced. However, Minde, (1974) states that in 1839 it was decided to erect a fence to separate the lunatics from the other patients. No record of

this could be found elsewhere, but if Minde is correct, the erection of such a fence might suggest that some of the lunatics were regarded as violent.

On the other hand, if the practice of confining violent lunatics in gaol was still in force in 1839, and there were no lunatics of this class in Somerset Hospital, the erection of the fence raises another question. One must ask why the lunatics were being segregated from the other patients.

Judging from Bailey's original advertisement the other inmates of Somerset hospital were likely to have been merchant seamen; slaves, servants and paupers. One finds it difficult to imagine that the hospital authorities would think it necessary to protect people of this social status from the sight of lunatics. One can only conjecture that this fence was the first of many barriers, actual or figurative, which were to segregate allegedly insane persons from the rest of the community in future years.

In recapitulation, the conclusion emerging from the obtainable records is that during the seventeenth and early eighteenth centuries in the Cape Settlement most non-violent lunatics appear to have been perceived as capable of functioning with a minimum of control. To a considerable extent they appear to have remained the responsibility of their families, or failing that, of the community.

By the mid-nineteenth century a tighter control over the insane is beginning to emerge, with a recognised lunatic asylum being established at Somerset Hospital. Records show that in addition to the alleged lunatics resident in Cape Town and it's immediate environs, lunatics from a considerable distance were also admitted. This suggests that such recognition would appear to have been authenticated, at least unofficially.

### Part 11

#### Comparative Survey of the British Asylum System

According to Burrows (1958), once the British had taken control of the Cape Colony at the beginning of the nineteenth century all the medical practitioners arriving in the colony had been products of the Medical Schools in London or Edinburgh. It might therefore be reasonable to assume that the policies they would be seeking to implement in the control of the insane in the new colony were reflective of those currently being practiced in England at that time. This suggestion would already appeared to have been affirmed in Part 1 of this chapter when it was recorded that Dr. Bailey proposed to operate the newly opened Somerset Hospital on principles similar to those in Europe.

Consequently it was decided to present an overview of the situation which, it is theorised, lead to widespread institutionalisation in England in the mid-nineteenth century;

to discuss the role of the asylums during that period and to compare these institutions with the earliest asylums established in South Africa.

## Part II (a) The Growth of the British Asylum System

By the nineteenth century England was being transformed, not only by industrialisation, but by the introduction of a policy whereby those seen as non-productive were relegated to institutions. This strategy was not exclusive to England, rather it was part of a post-revolutionary movement spreading throughout Western Europe. Although this section centres on conditions in England, outside influences will be discussed wherever applicable.

The policy of institutionalisation in England followed a fourfold pattern: vagabonds and criminals were to be controlled by an expansion of the prison system; the number of hospitals was increased; the parish almshouses which had cared for the aged, the indigent and the paupers since mediaeval times were transformed into inhospitable workhouses and vast asylums to house the allegedly insane were erected throughout the country. Skultans, (1979)

The growth of the asylum system was so rapid that by 1844 there were twenty-five county asylums in England, each accommodating between one thousand and two thousand patients. Shortly thereafter the demand for beds became so great that every one of England's forty counties was compelled by law to

provide at least one asylum within its boundaries. Scull, (1987) For the purpose of this study focus will be solely on the provision made for the lunatics.

At the beginning of the nineteenth century large lunatic asylums were virtually unknown in England. London's infamous Bedlam had contained only between 130 - 150 patients when it was moved to a new site in the late seventeenth century. This was enlarged during the eighteenth century, but even by 1844 contained only 265 patients. Scull (1979)

Both Skultans (1979) and Scull (1989) record that during the seventeenth and eighteenth centuries violent or criminal lunatics, not held in Bedlam, were kept chained to the walls of conventional prisons. The less disturbed were housed in special wards of general hospitals; remained within the community relying on their families or the parish for support, or were confined in small, privately-run madhouses. It will be re-called from Part 1 of the present chapter that similar conditions would appear to have applied to the lunatics in the Cape Colony over a comparable period.

It has not been possible to trace the extent to which lunatics were held in private dwellings in the Cape Colony, during the nineteenth century. The earliest traceable reference to private madhouses is in the Cape Lunacy Act of 1897. This Act contains a clause allowing the Colonial Secretary, on the payment of a fee, to grant a licence to keep a house for the reception of more than one lunatic. No other reference has been found to substantiate the location of these

premises nor to establish their prevalence, although the inclusion of such a clause in an Act of Parliament would appear to suggest such houses were relatively numerous. The size of such establishments and the social status of their patients would be of considerable interest, particularly when one notes that their English counterparts catered for both the parish paupers and the wealthier middle class.

Inconsistencies surround the extent of the private madhouse system in pre-industrialised England. Scull (1989) sees the madhouse system as being on a small scale, arguing that the number of madhouses was too small to be regarded as a system of institutionalisation. He asserts that this was a phenomena which only developed in the early half of the nineteenth century with the onset of industrialisation and the enforced migration of large sections of the population from a rural to an urban environment.

On the other hand Parry-Jones (1972) and Skultans (1979) maintain that throughout the eighteenth century institutional care in the form of madhouses was provided on a wide scale throughout England. They cite as their sources the Parliamentary Select committees set up in 1805, 1815 and 1827, and in addition Parry-Jones cites private communication from Charles Webster.

According to Skultans (1979) private madhouses could be divided into two categories, those for the wealthy and those for the paupers. In the former the staff/patient ratio was high and conditions acceptable. Unfortunately the same could not be said of the madhouses for paupers. All the private

madhouses were run for profit, and where patients or their families were able to pay well a reasonable standard appears to have been maintained. However, the vast majority of the madhouses accommodated pauper patients for whom the local authorities paid a pittance. If the premises were sufficiently large it was the practice to house the wealthier patients in the main building and confine the paupers to cellars or out-buildings. To make any profit out of the pauper lunatics it was necessary to cram them into grossly overcrowded accommodation, and in order to maintain control with a minimum number of staff the paupers were manacled, chained and subdued by violence. Skultans (1979)

Whether or not the number of private madhouses in England during the seventeenth and eighteenth centuries was too slight to qualify for the term "institutionalisation", it is clear they did establish the first form of control over the insane.

It has not been possible to trace any records of the numbers of lunatics accommodated in private establishments or in prisons in either England or South Africa prior to the building of the "official" asylums.

Scull (1989) asserts that during the early years of the nineteenth century a movement was begun to replace the private madhouses with state-funded asylums. Scull sees this movement as part of a much broader philanthropic social reform, which



aimed to remove the insane from gaols, workhouses and private madhouses and to seek out those "hidden in attics and closets", and to accommodate all in asylums, where they would be treated in a humane manner.

During the first quarter of the nineteenth century ten asylums all of average size, i.e. accommodating approximately one hundred patients, were built throughout England. Unfortunately the humane conditions envisaged failed to materialise. Because the overwhelming number of their patients were paupers, costs were cut, wards were grossly overcrowded and, for the most part, conditions were deplorable. Scull (1989)

This period would coincide with the opening of Somerset Hospital in Cape Town, and as already noted in Part 1 of the present chapter, conditions in that institution were reputedly on a par with those mentioned above. If the overcrowding and appalling conditions in British asylums and madhouses were, as Scull (1989) suggests, attributable, at least in part, to the majority of their patients being paupers, the same may be equally true in the case of Somerset Hospital. It will be recalled that these patients were predominantly paupers, slaves and servants for whom, no doubt a pittance would have been paid. Nor is it likely that the shipping agents or owners would be more generous in the fees they paid for any merchant seamen who were declared insane.

The earlier part of this chapter reported that Bailey was forced to vacate the hospital for some years on account of his financial difficulties. It is suggested that, here as in England, the financial status of the patients imposed strictures on the facilities the hospital was able to provide. However, as already stated, the English asylums were financed by public monies, while Somerset Hospital, in its early years was a privately funded venture.

While such a suggestion is advanced in mitigation of overcrowding and poor food, it in no way lessens the guilt of those in authority who were responsible for paying the fees of the paupers, slaves or servants. Once it was apparent that the sum paid for each lunatic patient was inadequate, steps should have been taken to increase payments. To ignore such circumstances was to further de-value those already deprived of their liberty.

Scull (1987), Skultans (1979) and Rothman (1971) are among the many writers who assert that an astronomical increase in the number of patients allegedly suffering from insanity was purported to have occurred in England during the first half of the nineteenth century. Even the provision of asylums of tremendous proportions, as previously mentioned, could not meet the demand for beds. In addition to the new asylums being constructed, existing buildings were constantly being extended in order to cope with the influx of patients.

Because of their relation to the changing perceptions of lunacy it was felt advisable to include the various explanations for the alleged phenomenal increase in lunacy in England in the mid- nineteenth century.

Part II (b) The Alleged Reasons for the Increase in the Number of Insane Persons in England during the First Half of the Nineteenth Century.

(i) The Correlation Between Capitalism and Institutionalisation.

The correlation between the rise of capitalism and the onset of institutionalisation in England is too strong to be ignored. If one takes as a comparison emergence of capitalism and the resultant urbanisation which followed the discovery of diamonds (1860s) and gold (1880s) in South Africa, and correlates this with the establishing of mainland asylums in this country a number of parallels emerge. As already stated, these asylums will be discussed in the final section of the present chapter these parallels, and possible differences, will be discussed at that point.

Scull (1987) maintains that the predominant reason for such an increase was the socio-economic upheaval caused by the enforced migration of the population from rural to overcrowded urban areas. He argues that whereas one lunatic in a village environment would create no marked difficulties, a number of

them living within a confined area could constitute major problems. Therefore the simplest and most satisfactory solution was seen to be their removal from the community and their confinement in asylums.

Scull (1979) is one of many writers who refer to the enormous numbers of "pauper-lunatics" whose families sought accommodation for them once the large asylums were available. The present writer cannot share the surprise expressed by Scull at the apparently low tolerance level of these families towards the afflicted members. Given the accumulation of overcrowded living conditions and subsistence level wages surely this is precisely the response one would expect. In addition, the feeding of an unproductive member of the family may have stretched their resources beyond the limits of endurance. It may also perhaps be assumed that in many cases the parents themselves possessed relatively low intelligence. Given such a genetic inheritance, coupled with a domestic environment devoid of intellectual stimulation, the likelihood of what we now term "cultural-familial" retardation would appear high. Such a condition frequently manifests a low tolerance level.

It may be simplistic to suggest that while no accessible amenities were available a family would struggle on alone with their problems, but once offered a feasible alternative they would welcome the solution. Such patients would therefore increase the number of applicants to asylums, but their

condition was not new. Previously it would have been a family concern, now it was a statistic.

Whilst the present writer concurs with Scull's argument to a large degree, it is suggested that he relies too heavily on socio-economic reasoning and places much less emphasis on the importance of the changing attitudes of the medical profession towards insanity.

(ii) The Advances in Psychiatry and Treatment of Mental Disorders.

In 1758 William Battie, Fellow and later President of the Royal College of Physicians in London wrote his Treatise on Madness, which Doerner (1969 p.41) describes as:

"the first psychiatric textbook and also the canon of formal components and institutions that made psychiatry into a combination of research, teaching and practice."

It is suggested that such a work would arouse considerable interest among members of the medical profession.

In France Philippe Pinel (1745-1826), as medical director of Bicentre, launched his "liberation of the insane". His book, *Traite medico-philosophique sur l'alienation mentale ou la manie*, appeared in 1801 and, according to Doerner (1969 p.128), "made Pinel the starting point of French - and German - psychiatry." Pinel theorised that when the chains

were removed from lunatics their rebelliousness would subside. Accordingly, in 1793, he struck off the shackles binding forty lunatics confined in Bicentre and removed the whips from the attendants. Pinel's action became highly publicised, a symbolic move towards freedom. In fact, such freedom was illusionary. On the same day the lunatics were placed in strait-jackets. Doerner (1969)

In 1805 Jean-Etienne-Dominique Esquirol (1772-1840) followed through the paradigm begun by Pinel, both theoretically and practically, bringing, according to Doerner, (1969) Pinel's model to fruition. In 1814 Esquirol offered the first clinical instruction in mental disorders and by the middle of the century numbered almost every French psychiatrist among his students. Doerner (1969)

It is acknowledged by many writers, Anastasi (1982), Skull (1989) among them, that the work of Esquirol in the 1830s focused the attention of the medical profession on the study of the human brain. Professional articles on the causes and treatment of insanity began to appear in English medical literature at the beginning of the nineteenth century and proliferated from then on. Skultans (1975). It would seem reasonable to conjecture this was the period during which the interest in insanity by both the medical profession, and the public at large, was at its zenith. This was also the period when the building of the great asylums was at its peak. By the close of the nineteenth century these huge institutions,

so recently erected, were to prove too costly to maintain. Skultans (1979).

Anastasi (1982 p.5) cited in Lea & Foster (1990 p.4) states:

" (The eighteenth century) had seen a strong awakening of interest in the humane treatment of the retarded and insane."

As the attention of the medical profession became more focused on the study of the human brain, it was widely believed that all mental deficiencies and disorders were curable. It would be reasonable to suggest that the greatest point of difference, apart from their patient capacity, between the smaller, original asylums in England and those constructed around the mid-nineteenth century was that they offered treatment, not simply confinement.

According to Skultans (1979) the new asylums claimed astronomically high success rates, some as great as 100%. Given the new parameters of insanity, such a claim takes on a new meaning. One may conjecture that the patients being successfully treated were, to a large extent, those suffering from minor mental disorders or stress-related conditions which improved once the patient was removed from the aggravating circumstances. No mention was made of those cases requiring re-admission.

Faced with such "irrefutable" proof of success, provided by the asylums in much published articles, it is hardly

surprising that families felt the asylums offered the best possible service to their afflicted relatives.

It has already been stated that the designation "lunatic" was a widely-embracing term. By the mid-nineteenth century not only did it cover all categories of mental retardation and mental illness but included alcoholics, epileptics, schizophrenics, all grades of depressives and what were termed "moral lunatics".

Although Hobbes had introduced the concept of moral madness in the mid-seventeenth century, it was not until 1833 that James Cowles Prichard coined the phrase "moral insanity" in his work *A Treatise on Insanity*. Prichard defined the term as:

"This form of mental disease has been said ... to consist of a morbid perversion of the feelings, affectations, habits, without any hallucination or erroneous conviction impressed upon the understanding; it sometimes co-exists with an apparently unimpaired state of the intellectual faculties."

*A Treatise on Insanity* (1833 p.14)  
(cited in Skultans 1975)

It will be shown in a later chapter the influence this concept of moral insanity was to have in South Africa during the years of the Depression.

Although England in the mid-nineteenth century did not witness the official classification of the allegedly insane into different categories, it is suggested that this period



saw the dawning of societal recognition that lunacy might be evidenced in varying degrees, some of which were now being pronounced curable by the medical profession.

The causes of insanity listed in Commentaries of Insanity (1828) or in Eleven Chapters on Nervous and Mental Complaints (1838) both cited in Skultans (1975) are so far-reaching one is amazed, not at the number of people afflicted, but at the fact that anyone escaped certification. Moseley (1838) alone lists thirty-one causes. These can be divided roughly into four categories:

| <u>External</u> | <u>Emotional</u>   | <u>Physical</u>                  | <u>Sexual</u> |
|-----------------|--------------------|----------------------------------|---------------|
| Excessive heat  | Jealousy           | Hunger                           | Masturbation  |
| Excessive cold  | Strong attachments | Alcoholism                       | Nymphomania   |
| Lightning       | Unrequited love    | Hereditry                        |               |
| Revolutions     | Terror             | Epilepsy                         |               |
| Political       |                    |                                  |               |
| upheavals       | Separation         | Influenza                        |               |
|                 |                    | Constipation                     |               |
|                 |                    | Brain tumours                    |               |
|                 |                    | Head injuries                    |               |
|                 |                    | Morbid condition of<br>the blood |               |
|                 |                    | Menopause                        |               |
|                 |                    | Puerperal fever                  |               |
|                 |                    | Overwork                         |               |
|                 |                    | Insufficient occupation          |               |
|                 |                    | Excessive study                  |               |
|                 |                    | Too strict an<br>upbringing      |               |
|                 |                    | Too lax an upbringing            |               |

It is therefore suggested that, given such a catalogue of etiology, medical practitioners would have good cause for declaring a patient insane at the least provocation.

Skultans (1979) writes of cases where women who blushed excessively were regarded as suffering from brain disorders.

Research by the writer in the records of asylums as far apart as The Towers Hospital, Leicester, England in 1970 and Town Hill Hospital, Pietermaritzburg, Natal, South Africa during 1993, revealed the cases of women who were committed, by their husbands, to the asylum for life on the grounds that "they wanted an excessive amount of sex". One wonders if both women were abnormally over-sexed or if the demands of each couple were simply incompatible. These examples are cited, not in a frivolous manner, but to emphasise the ease with which patients could be committed to asylums during the nineteenth century.

The present writer would accordingly suggest, not that insanity was increasing, but that societal perception of this condition was undergoing a metamorphosis. The parameters of insanity were widening to encompass those suffering from milder mental disorders. Public interest in insanity was aroused, one might almost infer that insanity had become "respectable", merely because it was a medically acknowledged condition and was regarded as curable.

As stated earlier, what had previously passed as eccentricity was now regarded as some treatable form of

illness. Thus the patient could be confined to an asylum, for his own good, and the statistics were increased once more.

It might be supposed that the emerging medical interest in the workings of the brain would result in more humane handling of lunatics. Prior to this, the ill-treatment of the insane in the private madhouses, in the original smaller asylums and in Bedlam was notorious. Rothman (1971) and Skultans (1979) are among the many writers who record accounts of patients left to lie on beds of filthy straw, of starvation, physical and verbal abuse, and of total neglect.

Because they lacked the mental capacity to think coherently the general assumption had, from the middle ages, been that lunatics also lacked the physical capacity to feel pain, hunger or cold. Langland (1330?-1400?) wrote:

"...And yet are there other beggars, apparently in health, but wanting in their wits, both men and women,  
Those that are lunatic, lolling and leaping  
or sit about as mad as the moon, more or less.  
They care not for the cold, nor take account of heat."

Skultans (1979) asserts that prior to the nineteenth century lunatics were regarded as animals, because they had lost their power of reasoning. It was common practice, at that period, for animals to be beaten into submission,

therefore, Skultans argues, it was considered permissible to treat the lunatics in a similar manner. Only through the influence of medical men like Pinel and Esquirol; political reformers like Shaftesbury, and humane philanthropists such as Tuke, was perception changed and the insane regarded as human beings. Tuke advocated a method of Moral Management, i.e., care of the insane without physical restraint and by appeal to the conscience and will of the patient, an idea considered revolutionary when introduced in 1792. (Details are provided in Appendix II.)

By the end of the eighteenth century and throughout the first half of the nineteenth, England and France were, each in a separate way, undergoing a process of revolution which was to metamorphosize their entire structure, socially, politically, economically and intellectually. The movement towards social reform brought a call for freedom, liberty and equality, and while this freedom did not extend to the lunatics in asylums, it did foster an awareness of their condition. On both sides of the Channel there were those who sought a more humane approach in the care of the insane. Improvements in the living conditions of the lunatics were, however, slow in coming. Many of the vast new asylums were modelled on the smaller older institutions, not only structurally, but with regard to conditions.

According to Skultans (1979) many of the new asylums continued in the use of physical restraint, harsh punishment, ill-treatment and neglect, which had prevailed throughout the old, smaller asylums and the pauper madhouses.

By contrast there was little recorded evidence of physical restraint or punishment being metered out to lunatic patients in Somerset Hospital. Burrows (1958 p.89) records that in 1826 Dr.J.Honey, the Resident Surgeon at that time, flogged a Hottentot woman lunatic "with horse traces while she was held down by two attendants" because she broke down part of her cell walls; smashed some eating utensils and was generally unmanageable. The Surgeon-Superintendent reported Honey to the Supreme Medical Committee, and he was subsequently removed from the staff of Somerset Hospital and appointed to the Leper Colony at Caledon.

Although this was the only traceable reference to the punishment of lunatics in Somerset Hospital, the comment of the Supreme Medical Committee would appear to suggest that flogging was, on occasion, administered:

"The Medical Committee regarded the practice of flogging as highly reprehensible and censured Honey for administering it himself. It was not in keeping with the decorum of the profession for practioners to flog patients, it held, in this case, the flogging could have been left to the female assistant to administer."

Burrows (1959 p.90)

There is also the question of the definition of "neglect". If conditions generally were described as "deplorable", one may perhaps conjecture that this infers neglect. The only

report of punishment to lunatics was in de Villiers, (1971) when he asserts that patients were locked into small, coffin-shaped "baths", with lids attached. When accused of administering such a punishment, asylum staff reportedly denied that this ever happened. One can only conjecture the horrific affect such treatment would have on mentally disturbed or mentally retarded patients.

The use of supposedly curative treatments for insanity in England appears to have been popularised early in the nineteenth century. This may have been due to the publicity given to the treatment of the supposed "madness" of King George III (1760-1820) in the later years of his life.

It would appear that the earliest, and most popular, methods employed in asylums were concentrated on voiding the body of impurities or administering shocks. One of the most highly acclaimed cures had been that of induced vomits and purges, often administered daily over a lengthy period. The rationale behind this treatment was simple. As the bodily impurities were evacuated from stomach, bladder and bowels, so would the impurities of the brain and the spleen, long believed to be the source of madness, be similarly released.

As the nineteenth century advanced those involved in the treatment of insanity appear to have developed a penchant for mechanical devices. Swinging or rotating machines which accelerated the voiding action were highly recommended by the medical profession during the 1820s. Mechanical devices which immersed the patients suddenly into icy water was purported to have a highly curative effect. Patients were also fastened

into coffins, the lids of which had been drilled with holes, prior to be lowered by mechanical means into water. Scull (1979).

It is to be hoped that these treatments were genuinely viewed as a form of shock therapy, although Guislain, cited in Scull (1979), suggests that the aim was to establish control over the patient, while not actually drowning him.

It could be suggested that patients suffering from mental disorders might be "cured" by the fear of a repetition of such treatment rather than by the treatment itself.

No mention is made of any specified treatment for lunacy in South African asylums during the nineteenth century. Writing of Somerset Hospital, Burrows (1958 p.111) quotes Bailey as saying that,

"Many hundreds of seafaring men visiting this port had not only been relieved but sent away with the blessing of restored health."

With such a testimonial it would appear likely that these men were patients in the general ward of the hospital, rather than the ward for lunatics.

With regard to Robben Island, it is not known what form of treatment, if any, was administered to the lunatic patients. Racial issues would appear to have dominated over curative issues. The only reference to treatment is that of Dr. Ross,

Physician-Superintendent of Robben Island asylum in 1888. Angered at being confronted by the low rate of cures compared to those in British asylums, retorted:

"No comparison can in fairness be instituted between the lunacy of savages and uneducated natives and the derangements of nervous systems met with among highly organised individuals living at the headlong pace of the nineteenth century."

De Villiers, (1971 p.89)

Although this comment reveals nothing about the use of curative treatment it indicates an awareness of the difference between what we would now term mental illness and mental retardation. It also illustrates the fact that black patients appear to have been regarded as incurable.

### (iii) The Awakening of Public Interest in Mental Disorders

A further theory on the reason for the alleged increase in insanity was propounded by Dr. Edward Hare, (1982). While delivering the Maudsley lecture to the Royal College of Psychiatrists in 1982. (British Journal of Psychiatry, Volume 144, 1984, pp.432-36) Hare argued that the rise in the number of "mad folk" could be accounted for by the abrupt development of medical interest in lunacy at the beginning of the nineteenth century and for the rapid publication of a series of treatises on insanity. Hare further asserted that, in his



view, this madness was what the psychiatric profession now calls schizophrenia, and that the probable etiology was a virulent viral infection laying waste the susceptible members of society.

While a detailed discussion on the merits of the latter assertion is beyond the scope of this study, the present writer would take issue over Hare's initial argument. She would contend that instead of the increase in madness fuelling interest within the medical profession, the reverse may, in fact, have been a more accurate explanation, i.e. that it was the publicity suddenly given to mental disorders which convinced a great many people that family members, formerly accepted as slightly eccentric, were displaying symptoms of insanity.

It would not be too far-fetched to suggest a parallel between the mid-nineteenth century rise in insanity and the present day, when the number of persons allegedly diagnosed as suffering from a certain physical illness will increase dramatically once public attention is focused on this condition.

The most obvious example must be myalgic encephalomyelitis, (M.E.). Recognition of the syndrome by the medical profession created public awareness of a hitherto obscure disease. Within a short space of time doctors were inundated by patients displaying the much-publicised symptoms and claiming to be suffering from M.E.

To describe M.E. as a "popular" illness would infer a mass desire to be proclaimed ill. Rather should the term "popularised" be used. With the combined attention of the media, the medical profession and the public at large focusing on this condition, those exhibiting one or two of the described symptoms imagined, rightly or wrongly, that they were suffering from the syndrome.

The diagnostic difficulties inherent in the identification of M.E. undoubtedly led to inaccurate conclusions on occasions. Thus, while the publicity attached to this condition may have helped sufferers to be identified and treated, it also created a considerable number of patients whose condition was suspect but unconfirmed.

If such diagnostic difficulties can arise amid the sophisticated medical technology of the late twentieth century, one may suggest that far worse problems arose in the identification of mental handicap and mental illness in the mid-nineteenth century.

It is therefore suggested that the supposed increase in insanity would, in no small part, be due to the publicity being given to brain disorders and the difficulty in diagnosing such conditions at that time.

Skultans, (1979) suggests that the parliamentary enquiries of 1788 and 1790 into the bouts of supposed madness which afflicted King George III (1760-1820) had further contributed to the growth of public interest in lunacy in England.

Consequently, the present writer would suggest that the publicity surrounding the treatment of brain disorders, plus, to use a modern metaphor, the emergence of lunacy out of the closet and into acceptability, accounted in no small way for the phenomenal increase in insanity during the nineteenth century.

(iv) The Need to Utilise the Asylum System Once it had Been  
Constructed

Mention has already been made of the sheer size of the new asylums. The assertion of many writers, Skull (1989) and Rothman (1971) among them, is that these institutions were built to meet the overwhelming demand by increased numbers of lunatics.

The present writer would posit an alternative suggestion. This is that the building of the asylums did not come as a result of the increased demand, but that both events occurred concurrently.

The Victorian propensity for exaggerated grandeur in their building concepts was at its height in the mid-1800s. This culminated in the Great Exhibition in 1851. Nothing in Victorian architecture was understated. Betjeman (1933) describes public buildings, from Town Halls to railway stations, as immense. The symbolism was clear, England was a great nation, her buildings must reflect this status.

Although the new asylums were financed by public monies it is reasonable to suppose that donations were always acceptable. In Victorian society philanthropy was highly merited, particularly among the nouveau riche seeking entry into society. Lunacy was becoming a "fashionable" branch of medical studies. Therefore what better cause than donations towards an asylum. Such an institution must, in keeping with the Victorian ethic, be immense, thus exhibiting the powerful control of the medical profession over insanity. Once having built such monumental structures the medical profession had to justify their existence by filling them. Given the developments already discussed, this could not have been too daunting a task.

South Africa, on the other hand was an emergent nation, with priority being given to the building of an infrastructure of roads and railways. Although a number of newly-built asylums, notably Town Hill in Natal, were architectural gems, others were conversions from derelict prisons or military barracks. Given the difference in the size of population, South Africa had no need to attempt to emulate the immense proportions of the English asylums.

It is of interest to note that in The Colony of the Cape of Good Hope Statistical Population Report 1843 the population of Cape Town was given as 22,543, while that for the area including the Eastern and Western Divisions of the Colony was 160,396.

At that date the number of alleged lunatics in Somerset Hospital, apparently the only facility in which the insane were confined in any number, was 38. This amounts to .169% for Cape Town and .024% if the figure for the whole area is used. Such a small percentage would appear to suggest that the perceived need to control non-violent lunatics was not great, and that many remained within the community.

A comparison with London for a similar period produces the following statistics. Population for the City of London in 1841 was given as 123,563, while the figure for the area described as the County of London was 1,872,365. (Encyclopaedia Britannica Vol.XIV 4th Ed.)

Although London was to have a major asylum, Colney Hatch, accommodating over one thousand patients in 1851, no trace could be found of any sizeable asylum, other than Bedlam, in the immediate vicinity in 1841. As previously stated, Bedlam accommodated 265 patients in 1844. Figures of patients who may have been in private madhouses or in general hospitals remained untraceable. Thus we see that using only the population of the City of London the percentage of population confined in Bedlam was .214%, while for the area of the County of London it was .014%.

What is felt to be interesting about the above statistics is the comparatively small variance in the percentages in each country, particularly when England was reputedly on the brink of a massive movement into the institutionalisation of the

allegedly insane. As appeared to be the case in Cape Town, it seems likely that in 1841 London authorities had not yet perceived the need for control, although this situation was soon to be rectified.

It should, however, be added that the above statistics applied only to London and its environs. If, as the writer will later suggest, industrialisation did play a major role in increased institutionalisation, then the picture may have been very different in the industrialised areas of the Midlands and Northern England.

Statistics comparing the rise in patient numbers which occurred in South African asylums over a corresponding period will be presented in a subsequent chapter. By the end of the nineteenth century the Cape Colony had provided five asylums of varying capacity, while another three were established throughout the remainder of South Africa. It will be shown that a number of derelict military barracks or former gaols were put to use as asylums and that initially not one of these institutions, new or converted, was capable of housing more than fifty-three patients.

In summation, this chapter began by investigating the earliest recorded mention of provision made for lunatics in the Cape Colony under Dutch rule. The conclusion was that apart from those who were allegedly violent, and who were consequently confined to the local goal, non-violent lunatics appear to have caused few problems.

Within two decades of British rule being established, the first hospital making specific reference to the accommodating of lunatics was established in Cape Town. It is suggested that medical personnel, newly arrived from Britain, would seek to replicate, at least to some measure, the provisions for lunatics which they had encountered in England. Therefore, the second section of this chapter surveyed the historical background to the British asylum system and sought to establish meaningful comparisons with the situation in the Cape Colony.

This chapter also contained a number of widely differing opinions of why there was an allegedly phenomenal increase in the number of patients admitted to asylums in England around the middle of the nineteenth century. Comparison will later be made with the number of patients admitted to South African asylums, once more institutions became available, towards the end of the nineteenth century.

Chapter IV will trace the course South Africa followed in establishing further asylums during the final quarter of the nineteenth century. The purpose will be to ascertain whether the needs of the insane were being perceived, and if so, how well society was responding to them.

## Chapter IV

### Historical Background - Asylums Throughout South Africa 1846-1894

The previous chapter has shown that during the mid-nineteenth century the nation-wide spread of asylums in England ensured that almost all those considered to be insane were kept in controlled segregation. The location of these institutions reinforced their isolation. It was standard policy that none should be built in close proximity to a town centre. Anyone choosing to visit the Victorian asylums still remaining would perhaps question this statement, but in every case, where an asylum is now within a city boundary, it is because suburbs have stretched far beyond the nineteenth century city limits.

The reasons given for the siting of the asylums was the benefits the patients would derive from peaceful surroundings and fresh country air. While one would like to accept this ethic, one cannot dispute the fact that many of these patients were never allowed outdoors. Neither can it be ignored that by siting these institutions in what were at that time relatively isolated areas the authorities were removing the so-called lunatics from the sight of the public.

The present chapter will begin by discussing the siting of the early asylums in the Cape Colony during the nineteenth



century, when under British rule, and will continue by examining the conditions which prevailed in these and similar institutions.

By choosing to locate Somerset Hospital at Green Point the British authorities in the Cape were repeating the pattern of isolating lunatics. Green (1975) asserts that for the greater part of the nineteenth century Capetonians drove out to Green Point Common in their gigs or carriages twice a year to attend race meetings, a highlight on the social calendar.

For the remainder of the year, according to Green (1975), Green Point was the Sunday playground for slaves. It may be that this custom ended when the slaves were officially granted their freedom 1834, but one might also conjecture that former slaves, now employed as paid servants in Cape Town, would continue to use Green Point as a leisure venue.

It would appear unlikely that the slaves were allowed to disport themselves near the homes of their masters, thus the indications are that the site of Somerset Hospital, at Green Point, was some considerable distance from the residential suburbs. This argument is further reinforced by the fact that the notorious Breakwater Prison was built next door to the hospital in 1846.

It has been mentioned earlier that a wall was erected within the grounds of Somerset Hospital for the purpose of segregating the lunatics from the other patients. Thus their isolation was further enforced.

Part I: The Removal of Inmates of Somerset Hospital to  
Robben Island.

In 1846 the British, at the instigation of John Montagu, Secretary to the Colonial Government, established an asylum at a site far more remote than Green Point. It was in the former convict colony on Robben Island.

The convicts were evacuated from the Island in order to provide labour on the mainland. Foster (1990) suggests this work was on much needed roads into the interior and that the convicts were housed in tented camps adjacent to the roadworks. According to Green (1975) the convict labour was badly needed for another project, that of building a breakwater to protect shipping in Table Bay from the winter gales.

If the convicts were in fact engaged in building the breakwater there is a certain irony in the situation. Breakwater Prison at Green Point was constructed to house the convicts working on the harbour project. Green (1975). The British in the Cape Colony had steadfastly refused to finance improvements at either Somerset Hospital or at Hemel en Aarde (the leper colony), choosing instead to ship both lunatics and lepers to Robben Island. It would appear that it was considered more expedient to build a prison in order to use convicts as a workforce, than to improve the living conditions of lunatics and lepers.

From an economic standpoint, the simultaneous transfer of convicts and patients was a master stroke of planning. Not only was free labour now available for badly needed building projects, but accommodation was immediately accessible for

those identified as being a social problem; the paupers, the chronic sick, the lepers and the lunatics.

It appears likely that the most decisive factor Montagu used in his argument for the planned transportation of the undesirables to Robben Island was that the Colony would derive great financial benefit on two counts from such a move. Montagu asserted:

a) that the leper establishments at Hemel en Aarde, Caledon, and at Port Elizabeth were both "wretchedly conducted, at a very heavy annual expense to the public"

b) "The land where the Somerset Hospital now stands, would sell for more money than it would cost to erect buildings for lepers and paupers, a lunatic asylum and a hospital for acute and chronic sick at Robben Island."

de Villiers (1971 p.48)

Although the abundance of stone and lime on Robben Island was freely available, the hospital Montagu supposedly envisaged was never erected.

According to the Dean of Cape Town, Newman (1855) the removal of the patients from Somerset Hospital to Robben Island afforded an improvement in their conditions. From a humanitarian viewpoint the transfer of these patients away from the mainland appears draconian in the extreme. Bearing

in mind the fear of contagion from leprosy, the removal of the lepers can perhaps be understood, if not condoned, but lunacy, poverty and chronic illness, with the possible exception of tuberculosis, were not considered contagious, therefore this line of reasoning could not be applied to these patients. Vitus (1987) suggests that lunacy was considered contagious during the nineteenth century, but the present writer has found nothing to substantiate this.

It is of interest to note that de Villiers (1971 p.48) quotes Montagu as saying that the sale of the land where Somerset Hospital stood would fetch more money than it would cost to erect an asylum, a hospital and other buildings on Robben Island. It appears doubtful whether this land was ever sold, because at the present time the New Somerset Hospital still stands in the same position. It might be suggested that Montagu's prime motive was to remove those considered socially undesirable, i.e. lepers, lunatics, and chronically ill paupers, from the environs of the rapidly developing Colony.

Burrows (1958) reports that by 1846 the Colonial Medical Committee had already been protesting over the unsuitability of Hemel en Aarde as a refuge for lepers. The Committee felt that any expenditure on this institution would be unwarranted and advised the move to Robben Island. Conditions at Somerset Hospital have already been described as grossly unsuitable, and unfit for use as a hospital. Faced with the amount of reconstruction and renovation necessary to transform the buildings into anything resembling adequacy, and considering the low worth which appears to have been placed on both lepers and lunatics, it is hardly surprising that the colonial government chose the cheapest option and merely removed the

disenfranchised to Robben Island. For the purpose of this study focus will be concentrated only on the plight of the insane.

Given the inaccessibility of Robben Island and the inadequacy of the premises vacated by the convict colony, it would have been reasonable to have expected a public outcry from the more socially aware members of the Cape community at the translocation of the patients, yet according to Minde (1947 b) and de Villiers (1971), few voices were raised in protest.

Such apathy must surely serve to illustrate the low esteem in which South Africans held the insane during the nineteenth century. Conditions on the island were appalling. De Villiers (1971) describes the existing buildings as decrepit and immediately overcrowded, with none of the promised extensions materialising. Hygiene facilities were virtually non-existent and the food unsatisfactory. Foster (1990). Yet, as mentioned earlier in this chapter, the British authorities considered conditions on Robben Island an improvement over those at Somerset Hospital.

One of the worst privations for staff and patients must have been the loss of contact with the outside world. Until 1894 when the heliograph was introduced, the only means of communication with the mainland was by boat or Pigeon Post. Report of the Commissioner in Mental Disorder (1918).

At certain times of the year Robben Island was totally isolated by storms. Under good conditions the journey over

the fourteen and a half kilometers took slightly under two hours. In bad weather it took twelve to fifteen hours, and one journey of twenty-two hours, during particularly bad weather, was recorded. de Villiers (1971).

The sub-title De Villiers (1971) uses for his book, "Out of reach, out of mind" could hardly have been more appropriate to describe the apparent attitude of Capetonians to the situation of the lunatics on Robben Island. Much can be learned about the approach of the British authorities when one considers their reaction to the reports of successive Commissions of Enquiry and Select Committees. Over a period of almost forty years the substance of these reports never changed: the buildings were in a ruinous state and totally unfit for their current use.

1852 The first select committee found the "lunatic asylum is altogether defective in its construction and arrangements...(and)...the attendance upon these poor creatures is decidedly inadequate."

No decision taken by Colonial Government.

1854 A select committee recommended the removal of all classes of patients on the grounds that Robben Island was totally unsuitable.

No decision taken by Colonial Government.

1855 Another select committee recommended removal suggesting a new hospital be constructed to house these patients.

No decision taken by Colonial Government.

1861 A further commission of enquiry issued a 300 page report recommending complete removal to the mainland.

No decision taken by the Colonial Government.

1862 Removal again recommended by a further commission.

No decision taken by the Colonial Government.

By this date, 1862, de Villiers reports that there were 166 patients, race unspecified, on the island.

In his 1918 report, the Commissioner in Mental Disorders states:

"Whenever these complaints gained strength plans seem to have been drawn up and approved for extensive improvements, only to be shelved again when it came to voting the necessary funds by the appointment of Select Committees or by Parliament resolving to remove the institution to a site on the mainland." p.7

The report carries no explanation for this inertia on behalf of the authorities, but the present writer would suggest the following theory.

De Villiers states that the findings of the above committees were disregarded because of a visit paid to the Robben Island Asylum by the Governor, Sir Philip Wodehouse (date unspecified, but prior to 1871). Wodehouse is purported to have been favourably inclined towards the asylum, therefore the government decided to let things remain as they were. If one visit by the Governor outweighed the findings of five select committees, one should perhaps seek to discover if the Governor had any interest or expertise in the administration of an asylum.

From the beginning of his tenure as Governor of the Cape Colony in 1862, Wodehouse would appear to have been immersed in almost continuous conflict with the British Government; with Shepstone in Natal; with Brand in the Orange Free State and with the Basotho chief over border conflicts. Atmore (1969) It is clear where his priorities lay. With costly territorial battles to be waged, it is hardly likely that Wodehouse and his supporters would vote monies to improve conditions for lunatics on Robben Island.

One of the most meaningful factors to arise from this research is what appears to be the hypocrisy of those in authority at this stage. By establishing successive Select Committees to investigate conditions on Robben Island the



British Government was absolved of neglecting the matter, yet every recommendation was ultimately ignored or rejected. One wonders how much public money was spent on such committees and on the publication of their subsequent reports, in one case three hundred pages in length.

The continued use of Robben Island as a lunatic asylum raises a number of other issues. According to de Villiers (1971) medical superintendents reported a number of incoming patients arriving without the prescribed certification of lunacy. The implications of this action were serious, but such allegations appear to have gone unchecked by the authorities on the mainland. Thus, in addition to the certified lunatics there were, over several years, a meaningful number of uncertified patients serving what amounted to life sentences in the asylum. One can only conjecture that once on the island their recourse to law would be minimal.

In addition to this injustice a form of racial segregation appears to have been put into practice on the island. This is the earliest recorded reference to such a policy in an asylum. According to de Villiers (1971) male lunatics were divided into two separate groups. Ostensively this was to separate violent and non-violent patients, but in effect the division was done almost entirely along racial lines. It would appear that the non-white patients were given the most exhausting physical tasks, while being relegated to the worst quarters.

In his annual report for 1918 Dr.E.F.W.Moon, Physician-Superintendent of Robben Island Asylum refers to a system of numbering patients which was started in 1862. This is the only traceable reference to such system and the purpose behind such a practice must be considered. It may be that this action refers simply to the patients' name being entered against a certain number in some form of register. On the other hand it may be that the patients were addressed by number in place of their names. No further reference to the numbering of patients could be traced, but if the latter policy was indeed the practice, then such a system can only been seen as a form of de-humanisation.

A comprehensive view of the situation then is that for almost forty years the British authorities chose to ignore the findings of successive committees; that the living conditions of the patients were thoroughly wretched; that the asylum contained uncertified patients in addition to those medically certified; that patients were discriminated against on grounds of race.

In 1890 some of the long overdue improvements to the accommodation for lepers and lunatics on Robben Island were finally undertaken with the provision of bathrooms, toilets and recreational facilities. Paradoxically, after enduring long years of deprivation, the removal of the majority of white lunatics from Robben Island occurred almost simultaneously with these improvements. By 1891 the first

thirty-six patients had been transferred to the new Valkenburg Hospital in Cape Town. Valkenburg Centenary Brochure (undated)

The fact that the improvements to the asylum on Robben Island and the building of a new asylum on the mainland happened at approximately the same time would appear to indicate a burgeoning interest in the welfare of the allegedly insane. This issue will be discussed in the following section.

Part II: The Establishment of Asylums on the South African Mainland

The initial establishment of asylums on the South African mainland covered the years between 1876 and 1894, during which time seven asylums were to open throughout the country. Details of the patient capacity of these institutions over a span of approximately thirty years will be presented in the following chapter.

The transfer of the majority of white patients from Robben Island to Valkenburg in 1890 may be seen as a change in the perception of the needs of the insane in South Africa. It is hoped that the following section will show whether there was an awakening of humanitarianism towards the insane throughout the country, or whether this was an isolated incident.

During the final two decades of the nineteenth century the colonies of South Africa chose diverse accommodation in which to house their allegedly insane patients. The movement

was towards removing so-called lunatics from gaols and general hospitals where they had previously been housed, and centralising them in asylums.

i) The Cape Colony

The action of the British Colonial authorities in their dispatch of social misfits to Robben Island has already been documented. The appeals by successive Surgeon Superintendents for an improvement in conditions were ignored until 1890.

The previous year Dr. William J. Dodds had been appointed Inspector of Asylums and it is suggested that it was he who was primarily responsible for the far-reaching repercussions. These arose as a result of a report written by the then current Surgeon Superintendent of Robben Island, Dr. William Henry Ross. Ross himself was found to have been inefficient in the administration of his duties, but it was his report which finally aroused concern for the patients on Robben Island. It was this report which Dodds brought to the attention of the Cape Medical authorities.

De Villiers (1971) records that in 1890 all buildings were repaired, altered and painted. Bathrooms, toilets and recreational facilities were at last provided. With the advent of official improvements came a newly awakened public concern towards the needs of the Robben Island community. According to de Villiers (1971) the patients now became the target for belated philanthropy from the citizens of Cape

Town. Visitors came over from the mainland to observe the situation for themselves. Groups of amateur singers and musicians came to entertain the patients and fund-raising efforts provided all sections of patients with Christmas gifts.

At approximately the same time as these ameliorations the removal of white patients from Robben Island finally began. By 1891 the first thirty-six patients, all Europeans had been transferred to the new Valkenburg Hospital in Cape Town, where Dodds had been appointed the first Superintendent in addition to his existing role of Inspector of Asylums for the Cape. According to the Valkenburg Centenary brochure (pages unnumbered), Dodds was determined that Valkenburg would not become "anything that should suggest thought of a prison or one of the old prison-like asylums." Gardens were planted, farming was instituted with the aim of making the asylum self-sufficient, and recreational facilities were provided.

When one considers the contrast between this attitude and that displayed some forty years earlier when the lunatics were transported to the appalling conditions in the former convict colony on Robben Island, one realises that societal perception towards lunatics was undergoing a considerable change. Burrows (1979) reports that of all the groups, lepers, lunatics, paupers and chronic sick, housed on Robben Island, the accommodation of the lunatics was the worst. The quarters for the women lunatics were described as a mere labyrinth of cells and passages. Prior to the arrival of Dr.

Minto in 1855 patients were not issued with cutlery, and had to eat all their meals with their fingers. Neither were they provided with sheets on their beds. In the absence of lavatories all patients had to relieve themselves in the bush.

It has been mentioned previously that Capetonian society appeared either unaware or apathetic about the conditions in which the patients were being kept on Robben Island. Burrows (1979) records one exception. It appears that a wave of public indignation swept through Cape Town in 1853 when it was discovered that there had been at least five pregnancies among the women lunatics since their arrival in 1846. There were calls for the women patients to be removed, but it would appear that the scandal died down without any such transfers taking place. The medical superintendent was reprimanded over the lack of supervision, but no further action was taken. One is left to conjecture whether such concern was for welfare of the women who may have been sexually abused by either staff or patients, or whether it was moral indignation over the idea of sexual relations between those who were allegedly insane.

It has already been mentioned that only around 1890 was there evidence of public awareness of the plight of the Robben Island patients. One wonders how far this contributed to the establishment of a mainland asylum and the transfer of the majority of the white patients in 1891. No record could be traced of any pressure being placed on the government to take action.

It may reasonably be assumed that by 1891 some of the wealth generated by the discovery of diamonds in Kimberley in the 1860s and the new deposits of gold discovered in the Transvaal in the 1880s was filtering into Cape Town. Access to overseas markets through the harbour would do much to create an upsurge in the economy of the Cape. It is possible that the humanitarians among those in authority felt a small percentage of such wealth could be afforded to upgrade the living conditions of the so-called lunatics.

At first glance it would appear that the only patients to benefit from the transfer to Valkenburg would be the white patients who were actually moved to the mainland. However, it has already been shown that many improvements had been carried out on the Robben Island asylum in the year immediately prior to this move. One must therefore assume that the building repairs, the bathrooms, toilets and recreational facilities, would be of benefit to the non-European patients still detained on the island. The continuance of visits and entertainments by the citizens of Cape Town once the white patients had been removed has not been recorded.

It has been suggested that an upturn of the South African economy played a part in the re-locating of the white patients. It may be coincidence that improvements in their condition corresponded with the election of Rhodes as prime minister of the Cape Colony in 1890. There is certainly no record that he was more sympathetic to the plight of the

lunatics than past governors had been, but there is always a possibility that one of his cabinet may have been sensible to their cause.

It was earlier suggested that Wodehouse chose to ignore the pleas of the medical superintendents for the transfer of lunatics from Robben Island to the mainland because his priority was centred on the constant issues of border conflict. If one accepts this argument, then the possibility of some influence on the part of Rhodes or his cabinet appears feasible.

Perhaps the strongest argument is that pressure may have been brought to bear on the authorities by Dodds. As previously stated, Dodds was both Inspector of Asylums in the Cape Colony, and upon its inception, Physician Superintendent of Valkenburg.

The centenary brochure of Valkenburg describes Dodds as a brilliant administrator. It may be that he also had a forceful personality and knew how to argue his case more effectively than the successive medical superintendents of Robben Island had done in the past.

Whatever the reason for such action, the removal of the first thirty-six patients from Robben Island would appear to indicate an emerging awareness for the needs of the insane by those in authority.



In view of such an auspicious beginning at Valkenburg, described above, one would hope that these improvements applied equally to lunatics across the racial barriers. Unfortunately such amenities were for white patients only. Even Dodds' staunchest supporters describe him as a racist (Valkenburg Centenary brochure) and he declared that Valkenburg Hospital should be used only for a "curable class of Europeans". It is perhaps due to his segregationist attitude that the non-European patients remained on Robben Island. It will be shown later that the numbers of black patients on Robben Island was actually to increase substantially over the next thirty years.

In 1894 an asylum for non-European patients was established at Fort Beaufort. This was in a former military barracks which had been unoccupied for several years. No reference to the condition of the property could be traced. Some time between its inception in 1894 and the early years of the twentieth century an enlargement was made by the inclusion of a building formerly used as a "Lock Hospital". The economic strictures under which this institution operated are clearly illustrated when one considers the reasons behind an experiment in housing native patients undertaken in 1908:

"Conry's Annexe, an experiment in housing native patients in huts, was laid out on land specially acquired for the purpose and occupied in April 1908. The original intention was to erect a new block for

100 patients at a cost of nine thousand, five hundred pounds. The actual cost of the annexe was one thousand, five hundred and eighteen pounds. The huts are substantially built, and have answered their purpose well."

Report of the Physician-Superintendent, Dr.H.E.Brown,  
Fort Beaufort Mental Hospital, (1918) Included  
in the report of the Commissioner in Mental  
Disorders, (1918 p.23)

As these were black patients one may assume that such dwellings would be more familiar to them than the European-style accommodation of the asylum buildings and that they would adapt more readily to their unfamiliar environment if housed in dwellings somewhat akin to their accustomed style. Bearing this in mind, one might have expected more experimental building along these lines.

The statistics shown in the addendum to Chapter V indicate a number of asylums where similar schemes might have alleviated the shortage of beds for black patients, yet no further record of hutted accommodation could be found.

The exclusion of black patients from Valkenburg was by no means an isolated incident. When they were finally admitted to this institution in 1916, it was not as patients in need of care, but as a work-force. It will be shown that this was apparently common practice.

A similar situation arose at the asylum in Grahamstown. Opened in 1895 in the disused military barracks at Fort England, this asylum originally catered for European and non-European chronic sick and insane patients, housing each race group in separate facilities. In 1908 this institution was declared open exclusively to Europeans. Black patients were removed, presumably to either Fort Beaufort or to Port Alfred where an asylum had been established in the old Convict Barracks.

Only after their transfer did the Fort England management realise how heavily they had relied on the black patients to provide a work force. With their removal the labour shortage became so acute that in 1916 a house on the property was converted into a native ward and "about thirty quiet and hardworking native and coloured patients were transferred to us with very appreciable advantages to the work..." . Report of the Commissioner in Mental Disorders (1918 p.21)

It would appear that where black patients were considered incapable of forming part of a work force they were relegated to the most inferior accommodation.

According to the report of Dr.W.H.Atherstone, Physician-Superintendent of Port Alfred Mental Hospital (included in the 1918 report of the Commissioner in Mental Disorders), the need to provide accommodation for the steadily increasing number of patients forced the government to take over the vacant Convict Barracks at Port Alfred and convert them into a hospital for mental patients.

Even at its inception in 1888 the mental hospital at Port Alfred was described as "quite unsuitable" for the fifty-two patients consigned there. In 1899 a ruined workshop was converted into three additional dormitories and a day room. No record could be traced of further extensions although by the time of the report (1918) there was a total of two hundred and eighty-six patients in the institution. Of this number only sixty-six were white and all of these were described as "chronic cases, transfers from other asylums." (Report of the Commissioner in Mental Disorders 1918)

Perhaps one might infer that the patients transferred here were those least likely to complain.

#### ii) The Orange Free State

In the Orange Free State a temporary asylum, Oranje Hospital was established in Bloemfontein in 1876 for both European and black patients. It appears that the building of a permanent structure was delayed year after year and it was not until 1889 that the new hospital was finally opened.

The centenary brochure published by this hospital, DIE GESKIEDENIS VAN DIE ORANJE HOSPITAAL 1884 - 1986 states that this new hospital originally accommodated only ten patients. Elsewhere in this publication it is stated that in 1875 the Volksraad had resolved that all mental patients throughout the Orange Free State should be brought to Bloemfontein. Even allowing for the relatively low population of the Orange Free State in the 1870s (see tables in addendum), this would appear

to be an under-estimation of the beds required. It is noted that native patients provided the labour both in the building process and later in the servicing of the European wards.

### iii) The Transvaal

A purpose-built asylum was opened in Pretoria in 1892 to house lunatics previously held in gaols and private houses. It may be that these houses were the private madhouses referred to in a previous chapter, but no statement to this effect could be traced. The original number of patients is not recorded. By 1901 almost two hundred patients, white and non-European, were housed in this institution. In order to establish a tighter system of racial segregation a new institution for Europeans was opened in 1907. (Report from Dr.J.T.Dunston, Physician-Superintendent, Pretoria Mental Hospital, 1918)

One point of interest regarding the Pretoria Mental Hospital is that it was the only asylum in South Africa to be constructed along the lines of an English asylum. The disadvantages of having been designed by an architect unfamiliar with the South African climate were soon apparent.

Firstly, Menston Asylum in Yorkshire, on which the designs were based, was built to house 2,000 patients, and according to Dunston, (1918) the reduction in size to accommodate a maximum of 430 patients was unsuccessful.

Secondly, and foremost among the complaints, was the absence of suitable verandahs to provide shading from the sun.

New buildings were gradually added until, in 1918 Dunston reported that there were 846 European patients and 653 non-Europeans housed in segregated accommodation. Once again labour appears to have been provided by the non-European patients.

#### iv) Natal

The brochure of Town Hill Hospital 1880-1986 states:

"...in 1868 there were 20 lunatics in hospitals in Durban and Pietermaritzburg and many more in the local jails. The problems became so great that the Governor of Natal appealed to the Governor of the Cape to admit Natal's lunatics to the asylum on Robben Island. This request was turned down, and therefore, the Natal Government decided to build a temporary lunatic asylum at the Pietermaritzburg jail for about 20 patients. This temporary asylum served Natal until Town Hill Hospital was completed in 1880."

Although local archivists were unable to confirm the existence of this temporary asylum, Hattersley (1960) asserts that in the 1870s such an institution did exist in Pietermaritzburg. Quoting an unspecified source, Hattersley, (1960 p.59) states that in 1874 this asylum was described as

"that miserable place", housing "mild" lunatics who had previously been sent to Grey's hospital.

Assuming Hattersley to be correct, the temporary asylum in Pietermaritzburg pre-dates all other South African asylums with the exception of Somerset Hospital and Robben Island.

It is perhaps interesting to conjecture that if the Governor of the Cape Colony had acquiesced to the request for Natal's lunatics to be moved to Robben Island, the temporary asylum, and ultimately Town Hill Hospital in Pietermaritzburg, might never have been built.

The fact that the Natal authorities contemplated sending these alleged lunatics a distance of some 1,600 kms from their homes indicates the lack of concern for patient welfare. To have dispatched these people over such a distance in the mid-nineteenth century would almost certainly have meant a total severance of family links for the remainder of their lives.

Although the policy of segregation was practiced in Natal from the inception of Town Hill Hospital in 1880 with the classification of patients into Whites, Indians, and Blacks, accommodation for non-Europeans appears to have been of a somewhat higher quality than in other asylums. Once the new main building was opened in 1891 the non-Europeans were housed in the old White wards and in 1905 new premises, solely for Natives and Indians were completed. However, it will be

noted that once again the oldest and presumably least desirable buildings were used for the black patients.

According to the Town Hill Hospital Centenary Brochure before the end of the nineteenth century tennis, croquet, cricket and bowls facilities were available for patients and concerts and dances were arranged on a regular basis. The grounds were exceptionally well developed and patients wishing to participate in tending the gardens were encouraged to do so. Town Hill Hospital brochure 1880-1986.

The brochure fails to record whether their admirable range of sporting facilities was available equally to patients of all races, but given the racial climate of that era it appears highly probable that these were reserved solely for the whites.

Under several different titles since its inception this institution has continued to serve as a psychiatric hospital for over one hundred years.

Throughout South Africa it would appear that the criteria for segregation no longer rested between dangerous or violent lunatics and plain lunatics, as it had done in the eighteenth century. Now, by the closing decades of the nineteenth century, the determining factor in accommodating a lunatic was largely one of race. Furthermore, within each race group there appears to have existed a two-tier system.



Those white lunatics considered curable were perceived as requiring the highest grade of accommodation, while those regarded as incurable were housed in less salubrious premises.

In every province the accommodation afforded to non-European patients was inferior. Here again there was a two-tier system but for the blacks the differentiation appears rather to be between those capable of providing a work-force and those who were not. Being unproductive possibly indicated that the patient was also regarded as incurable and as such would be accorded the most inferior form of accommodation.

This chapter traced the establishment of asylums from Robben Island to provincial institutions throughout South Africa. Some evidence of a desire to improve conditions in the asylums was discernible.

Although conditions on Robben Island were deplorable, they were apparently an improvement on those at Somerset Hospital. It has been mentioned that shortly before the transfer of white patients to Valkenburg, some of the long-awaited improvements to the asylum on Robben Island were finally undertaken. It would also appear that, around the same time, the citizens of Cape Town developed a certain degree of social consciousness by visiting Robben Island and raising funds to provide patients with badly-needed comforts. The hope was expressed that this form of voluntary work did not cease when the majority of European patients were transferred from Robben Island and only non-Europeans remained.

Those asylums which were newly built were undoubtedly an improvement on the premises on Robben Island but it has not been possible to quantify the standard of accommodation in those institutions assigned to former military barracks or convict colonies.

One clearly discernible thread is that the policy of controlling the insane was strengthened by the establishment of provincial asylums. Those previously housed in gaols or hospitals could now be brought into centralised institutions, thus facilitating tighter control. The other developing theme is that of racial discrimination, with the blacks consistently being allocated the least desirable accommodation.

Chapter V will discuss the patient capacity of these asylums and will present statistics showing the increase in population and any commensurate rise in so-called insanity.

## Chapter V

### Numerical Increases in Institutionalised Persons in South Africa 1890-1918

Chapter IV presented a survey of the provision made for the allegedly insane in asylums throughout South Africa during the final two decades of the nineteenth century. Improved conditions for European patients since the days of Somerset Hospital and Robben Island suggest a growing social awareness among society over the conditions to which the so-called lunatics were subjected. The first records of racial segregation were traced to the asylum on Robben Island, and from the onset of institutionalisation on the mainland, black patients were consistently housed in inferior accommodation.

The present chapter will show the numerical increase in patients in South African asylums over a period of roughly thirty years, commensurate with the rise in population. The purpose of this statistical review is to ascertain whether South Africa underwent a similar increase in so-called insanity, comparable to that which allegedly took place in England over a corresponding time-span, once a system of institutionalisation had been introduced.

It is hoped that these results will show some indication of whether South Africa adequately perceived the needs of those considered to require institutional care.

Although records traced to the nineteenth century are on occasion sporadic it was felt that sufficient evidence could be amassed for this to indicate trends and priorities. Unfortunately not all the institutions were able or willing to supply these figures and these omissions prevent this survey being as detailed as originally intended.

The statistics are shown in the addendum to Chapter V. Tables I, II, & III have been obtained from the Report of the Commissioner in Mental Disorders 1918 and from the records of the institutions concerned. Because the diverse terms used to describe the non-white race groups frequently make definitions unclear, the division is simply into European and non-European.

In order to present a more composite picture for discussion only total increases have been abstracted from the full tables.

The following figures are taken from Table I:

Valkenburg 1891 - 1918 increase of 777 patients

Grahamstown 1875 - 1918 increase of 459 patients

Port Alfred 1888 - 1918 increase of 234 patients

Fort Beaufort 1894 N/A\* 1913 - 1918 decrease of 56  
patients

Robben Island 1846 - 1918 increase of 386 patients

Pietermaritzburg 1880 - 1918 increase of 760 patients

Bloemfontein 1873 - 1918 increase of 566 patients

Pretoria 1892 - 1918 increase of 1446 patients

\*N/A = not available

Before attempting to determine the relevance of the above figures it is necessary to consider the simultaneous increase in population in each of the colonies over a comparable period. Fuller statistics are shown in Tables II & III. Prior to the population census of 1890/1 figures available were for the Cape Province only.

|        |           | <u>European</u> | <u>Non-European</u> |
|--------|-----------|-----------------|---------------------|
| 1890/1 | Cape      | 376,987         | 1,150,237           |
|        | Natal     | 46,788          | 497,125             |
|        | Transvaal | 119,128         | N/A                 |
|        | O.F.S.    | 70,716          | 129,787             |
| 1918   | Cape      | 618,825         | **2,132,110         |
|        | Natal     | 121,931         | **1,292,560         |
|        | Transvaal | 499,347         | **1,544,151         |
|        | O.F.S.    | 181,678         | **440,271           |

\*\*Figures only available for 1921, N/A for 1918.

The problem of collating statistics was exacerbated by the practice of conducting the census of the European population every five years, while the census of other races was conducted at ten-yearly intervals, i.e. 1911 and 1921.

It had been the intention to include a fourth table showing the percentage of the population institutionalised in 1890/1 and again in 1918. Although every effort was made to obtain statistics on the numbers of lunatic patients in hospitals, gaols or other institutions in the years 1890/1 (prior to the establishment of provincial asylums) lack of available data precluded a fully comprehensive table.

The figures below will give some indication of the percentage of the population institutionalised in the first post-Union census.

|                      | <u>Population</u> | <u>Institutionalised</u> |
|----------------------|-------------------|--------------------------|
| Europeans - 1918     | 1,421,781         | 1,855 = .300%            |
| Non Europeans - 1921 | 5,409,092         | 2,758 = .040%            |

The obvious disparity between the racial groups should be seen not as an indication of a higher rate of lunacy among the Europeans but rather as a sign of negligence in the identification and certification of insanity among the non-European races. This is an area which will be discussed in a subsequent chapter.

Conclusions Drawn from the Above Statistics:

a) Initial Patient Capacity in South African Asylums

It is suggested that the medical profession in South Africa seriously underestimated the provision required to meet the needs of those certified as insane in the latter half of the nineteenth century and the early decades of the twentieth.

Statistics would attest to an underestimation of the number of beds required in many institutions. (See Table 1) Overcrowding in South Africa's asylums will be discussed later in this section. At the present point the writer would like to draw attention to what appear to be gross inadequacies in planning by giving just two examples.

Town Hill Hospital, Natal

As already shown in Chapter IV, The Centenary Brochure of this hospital (1880-1986 p.5) states:

"...in 1868 there were 20 lunatics in hospitals of Durban and Pietermaritzburg and many more in local jails",

yet when a temporary asylum was built in Pietermaritzburg it had a capacity for only twenty patients. Twenty-two years later the newly built asylum at Town Hill was designed to accommodate only 37 patients. It should be borne in mind that this asylum had to cater for the entire colony of Natal.

Pietermaritzburg and Durban were towns of ever-increasing proportions, while throughout the province there were recently established towns with developing populations.

When planning Town Hill Hospital the authorities in Natal could not have remained unaware of the numbers of lunatics awaiting accommodation in the hospitals and gaols. One can only speculate whether this unrealistic approach was the result of severe financial strictures or a refusal to accept the fact that an increased population would be commensurate with an increase in the number of persons needing institutional care.

#### Valkenburg, Cape Town

Although apparently never used for that purpose, the premises occupied by the asylum at Valkenburg were originally intended for use as a reformatory. This may account for the fact that initially Valkenburg could accept only thirty-six patients.

Again, it would be reasonable to question why no additional provision was made for prospective patients when the population of Cape Town, and consequently the proportion of those in need of institutional care, was increasing so rapidly. One must assume such a decision was based on financial circumstances. If this is so it is of particular interest to note a slightly later development gazetted under Temporary Loans Act No. 17 of 1894 which reads:



"For the purpose of constructing and equipping a Lunatic Asylum upon a site adjoining the existing Valkenburg Lunatic Asylum it shall be lawful for the Governor to apply a sum of forty thousand pounds out of moneys authorised to be raised under the provisions of the Temporary Loans Act."

Such legislation would appear to indicate a changing perception by those at government level either of the increasing numbers of the allegedly insane, or of their needs. Unfortunately, this appears to have applied to Valkenburg Asylum only. Other institutions within the Cape Colony continued to be inadequate and in some cases almost derelict. It cannot be ignored that Valkenburg catered solely for white patients who were considered curable. It would appear an elitist system was in operation whereby money should be spent on one race group and particularly those within that group who were considered to have a reasonable chance of recovery. In today's parlance such patients would probably be the mentally ill rather than the mentally handicapped. Nor should it be overlooked that Valkenburg was in Cape Town, the principal city and political capital of the colony.

Strangely, no further record of the loan gazetted in 1894 could be traced. Burrows, (1959) in his history of medicine in South Africa makes no mention of it, neither is there any reference in the Valkenburg Centennial Brochure (undated).

In 1894 forty thousand pounds would have been an enormous sum. It is ironical to remember that requests for far lesser amounts, made by successive superintendents of Robben Island, were always rejected on the grounds of economy. One must conclude that the granting of a loan of this magnitude was a reflection of the upswing in the South African economy.

b) The Increase in Persons in Need of Institutional Care

Table I (see addenda) demonstrates a steady increase in patients at seven of the eight asylums in South Africa between the opening of these institutions and 1918. (This period was judged as a meaningful time-span over which reliable figures were available.) Such an increase correlates approximately with the increase in population displayed in Table II (see addenda).

The one exception is Pretoria Asylum. After following the normal pattern of increase until 1917 the subsequent two year period shows a phenomenal upswing, i.e. an increase of 99 European patients in 1917 and a further increase by 152 European patients the following year, amounting to an increase of 251 European patients in two years. As the number of beds in the European section had remained static at 570 from 1913 this would have amounted to an excess of 276 patients over the number of beds.

These statistics are repeated in both the annual report of the Physician Superintendent of the asylum and in the figures quoted in the 1918 Report of the Commissioner in Mental

Disorders, but the possibility that such figures may have been repeated without verification cannot be ruled out. These figures are not commensurate with a sudden upsurge in population, nor could any recorded explanation be located.

Assuming the accuracy of the figures, it is tempting to advance possible theories. One explanation may be that troops returning from the theatre of war in Europe suffered extensively from shell-shock and the trauma of trench warfare and were admitted into Pretoria Asylum. One would have expected such an event to have merited a mention in the annual report of 1918. An exhaustive search of available records failed to shed any light on this matter. Pretoria Hospital has failed to respond to written and verbal requests for information.

#### c) Overcrowded Conditions in the Asylums

The first annual report of the Commissioner in Mental Disorders 1918 focuses primarily on the problem of overcrowding in each of the asylums throughout the provinces from their inception up to the date of writing. Subsequent reports were to reinforce this problem annually.

The earliest dated statistics showing numbers of available beds are for 1913 and spread over a six year period. Briefly an overview of the available statistics shows the following:

|            |           |                                  |
|------------|-----------|----------------------------------|
| Valkenburg | 1913-1915 | overcrowding (European patients) |
|            | 1916-1918 | no overcrowding in any ward      |

|                  |           |                                                                       |
|------------------|-----------|-----------------------------------------------------------------------|
| Grahamstown      | 1913-1915 | overcrowding (European patients)                                      |
|                  | 1916-1918 | no overcrowding in any ward                                           |
| Port Alfred      | 1913-1918 | no overcrowding except for one instance in non-European wards in 1915 |
| Fort Beaufort    | 1913-1918 | no overcrowding                                                       |
| Robben Island    | 1913-1915 | overcrowding in European wards                                        |
|                  | 1916-1918 | almost all European patients removed                                  |
|                  | 1913-1918 | consistent overcrowding in non-European wards                         |
| Pietermaritzburg | 1913      | no overcrowding in European wards                                     |
|                  | 1914-1918 | overcrowding in European wards                                        |
|                  | 1913-1918 | consistent overcrowding in non-European wards                         |
| Bloemfontein     | 1913-1915 | no overcrowding in European wards                                     |
|                  | 1916-1918 | overcrowding in European wards                                        |
|                  | 1913-1916 | overcrowding in non-European wards                                    |
|                  | 1916-1918 | surplus of 300+ beds in non-European wards                            |

|          |           |                                               |
|----------|-----------|-----------------------------------------------|
| Pretoria | 1913      | no overcrowding in European wards             |
|          | 1914-1918 | overcrowding in European wards                |
|          | 1913-1918 | consistent overcrowding in non-European wards |

This summary was based on Table I in the addendum.

Of the eight asylums listed only Fort Beaufort experienced no instance of overcrowding in the eight year period covered by the investigation.

In the case of European patients twenty-three of the reports issued annually by the medical superintendents of the institutions allege overcrowding. In the case of non-Europeans, overcrowding is alleged in twenty-two of the reports. It would therefore appear that this problem applied equally to all races. However, the total number of "excess" patients referred to over this six year period was 1,009 Europeans and 1,512 non-Europeans. It would therefore appear that the non-European institutions were overcrowded to a far greater degree than those for European patients.

One unexplained factor occurs in the records of Bloemfontein Asylum in 1917. Although no reference is made to this event in the centenary brochure issued by the institution, statistics from the 1918 Report of the Commissioner in Mental Disorders show an increase by 490 beds in the black sector of the asylum. This figure does not equate with an increase in patients and perhaps doubt should be cast on its validity. If

this is taken as accurate, one would expect to discover a significant number of transfers from other asylums, but this was not the case. Legislation had been passed in 1914 which allowed transfer of lunatics between provinces where overcrowding was excessive. One may conjecture that extra accommodation was provided to meet such an eventuality, but for some unexplained reason remained unoccupied for a number of years. This legislation will be discussed in the following chapter.

This chapter concludes that there was no sudden unexplained upswing in insanity in South Africa commensurate with the establishment of an asylum system, as had occurred in England. Overall the increase in insanity followed the accepted pattern compatible with the rise in the population.

It also appears that the South African authorities in every province underestimated the numbers of lunatics in need of institutionalisation. The State sought to establish control of the insane, yet failed initially to perceive the numbers involved.

Racial segregation was enforced in every asylum, with inferior accommodation inevitably being assigned to the non-Europeans. The native patients were frequently used to supply labour both in the construction and the servicing of institutions reserved for European patients.

The immediate pre-Union years had witnessed the establishment of asylums in each of the South African

provinces. This form of institutionalisation was necessitated by those in authority perceiving a need to control the insane. In many instances such a perception may more accurately be viewed as a stance against moral, rather than mental, deficiency, and this attitude will be discussed in a subsequent chapter.

Previously the writer has proffered reasons for the alleged phenomenal increase in lunacy in England during the onset of the asylum system. The number of asylums provided in South Africa during the final quarter of the nineteenth century was, in the opinion of the writer, too small to warrant the term "system". It is suggested that this fact provides a clue to why no comparative increase occurred in this country.

The writer would suggest that the timing of institutionalisation should be considered. England, by the nineteenth century was an established world power, about to emerge as a highly industrialised, capitalist nation. There was large scale migration from rural to urban environments. It was the age of invention, thus enabling the country to progress to an era of mass production. As stated earlier in this study, it was the beginning of an age when to be unproductive was regarded as a liability.

By contrast, South Africa was an emerging nation, with a fraction of England's population. The discovery of rich mineral deposits revolutionised the country's economy, but although migrations to these areas created cities, neither the shift in population nor the resultant urban areas could in any way be compared with the overcrowded metropolises of England.

Thus, it is suggested, large asylums were never envisaged for South Africa. Rather, as the tables in the addendum to the current chapter show, it appears that the number of beds required was severely underestimated, a situation which was not to be remedied for many years.

It is also felt that the socio-economic scene in South Africa towards the end of the nineteenth century should be considered. It has been suggested that in England two groups of patients appear likely to have predominated in the vast new asylums. Firstly those suffering from what we would now term mental illness. It has earlier been suggested that the publicity given to the treatment of disorders of the brain may have played a role in convincing large numbers of people, rightly or wrongly, that they needed institutional help. The asylums were being erected, therefore such help was at hand.

Because the construction of asylums in South Africa took place some thirty or forty years later, it is suggested that the initial excitement over such treatments had given way to a more cautious approach, with the realisation that not every facet of so-called insanity was curable.

Also, it should be added that the South African population, away from the main urban areas, was sparsely scattered over a



wide area. Consequently identification of those in need, particularly among the black communities, was a greater problem than in England.

By far the largest social group in the English institutions were, apparently, the paupers. In South Africa towards the end of the nineteenth century poor whiteism had not yet become an extensive problem. Therefore the vast majority of those in the pauper class would be non-Europeans. It is suggested that the figures of non-Europeans in need of institutional care would have been considerably higher had the government made more effort to identify the problem of insanity in races other than European.

If poor whiteism was not recognised as a widespread problem at the end of the nineteenth century, a change was shortly to take place. Later in this study the supposed correlation between poor whiteism and feeble-mindedness will be discussed. This was to be deemed one of the worst problems in the field of mental health in the early post-Union period.

At the outset of this study it had been anticipated that the hardship of wartime conditions may have adversely affected the facilities provided for the insane. Although available records refer to restrictions on building requirements and staff shortages during both World War I and World War II, these amount to no more than the depredations experienced in general hospitals. (Records supplied by Grey's Hospital and the 1918 Report of the Commissioner in Mental Disorders.)

It would appear that the greatest calamity experienced by the asylums nationally was the influenza epidemic in 1918 and this was, of course, a catastrophe which affected all sections of the population. Reading Dunston's report one might feel that the epidemic had almost assumed the character of a blessing in disguise:

"...Had it not been for the influenza epidemic the overcrowding would have been greater."

Report of the Commissioner in Mental Disorders (1918).

The present chapter has dealt with provision made for the physical accommodation of lunatics. Commensurate with the establishment of the asylums came new legislation appertaining to the insane. Chapter VI will examine the acts that were promulgated during the nineteenth century.

ADDENDA TO CHAPTER VTABLE 1INCREASES IN INSTITUTIONAL PROVISION FOR THE ALLEGEDLY INSANE  
IN SOUTH AFRICA PRIOR TO 1918Valkenburg - Opened 1891 36 PatientsIncreased to 428 Patients (all European) 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 458      | 520      | -            | -        |
| 1914 | 458      | 542      | -            | -        |
| 1915 | 604      | 578      | -            | -        |
| 1916 | 744      | 686      | 60           | 56       |
| 1917 | 744      | 697      | 82           | 77       |
| 1918 | 839      | 748      | 96           | 65       |

Total increase between 1891 - 1918 = 777 patients

It will be shown in a later section that Valkenburg housed only those classified as 'curable white patients'. The assumption therefore is that the black patients included from 1916 onwards were there to provide a work force.

Grahamstown - Opened 1875 22 PatientsIncreased to 403 Patients (all European) 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 330      | 385      | -            | -        |
| 1914 | 349      | 392      | -            | -        |
| 1915 | 352      | 384      | -            | -        |
| 1916 | 398      | 399      | 28           | 28       |
| 1917 | 425      | 419      | 34           | 27       |
| 1918 | 491      | 450      | 34           | 31       |

Total increase between 1875 and 1918 = 459 patients

The 31 black patients were employed as a work force.

## II

### Port Alfred - Opened 1888 52 Patients

Increased to 79 European and 204 Non-European Patients 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 91       | 89       | 221          | 226      |
| 1914 | 91       | 89       | 250          | 242      |
| 1915 | 91       | 90       | 250          | 271      |
| 1916 | 91       | 90       | 250          | 238      |
| 1917 | 91       | 86       | 250          | 247      |
| 1918 | 69       | 66       | 250          | 220      |

Total increase between 1888 - 1918 = 234 patients

Patients all transfers from other asylums, all regarded as incurable.

### Fort Beaufort - Opened 1894 (figures not available)

480 Patients (all Non-European) 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | -        | -        | 600          | 589      |
| 1914 | -        | -        | 605          | 590      |
| 1915 | -        | -        | 605          | 594      |
| 1916 | -        | -        | 605          | 557      |
| 1917 | -        | -        | 605          | 588      |
| 1918 | -        | -        | 605          | 533      |

### III

Robben Island - 1846 50 Lunatic Patients transferred from  
Somerset Hospital and other institutions

56 European and 399 Non-European Patients remaining 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 44       | 64       | 410          | 417      |
| 1914 | 44       | 61       | 410          | 429      |
| 1915 | 44       | 59       | 410          | 433      |
| 1916 | -        | 5        | 401          | 392      |
| 1917 | -        | 1        | 433          | 409      |
| 1918 | -        | 1        | 433          | 435      |

Total increase in patients between 1846 - 1918 = 386

Pietermaritzburg - Opened 1880 37 Patients

Increased to 255 European and 334 Non-European Patients 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 309      | 288      | 293          | 344      |
| 1914 | 294      | 311      | 293          | 332      |
| 1915 | 317      | 343      | 293          | 373      |
| 1916 | 317      | 327      | 293          | 419      |
| 1917 | 317      | 347      | 293          | 447      |
| 1918 | 317      | 355      | 293          | 442      |

Total increase in patients between 1880 - 1918 = 760

IV

Bloomfontein - Opened 1873 10 Patients

Increased to 116 European and 157 Non-European Patients 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 136      | 136      | 190          | 216      |
| 1914 | 136      | 129      | 190          | 202      |
| 1915 | 136      | 133      | 190          | 215      |
| 1916 | 163      | 165      | 187          | 235      |
| 1917 | 163      | 186      | 677          | 282      |
| 1918 | 163      | 197      | 677          | 379      |

Total increase in patients between 1873 - 1918 = 566

Pretoria - Opened 1892 53 Patients in 1894

Increased to 355 European and 358 Non-European Patients 1910

| Date | European |          | Non-European |          |
|------|----------|----------|--------------|----------|
|      | Beds     | Patients | Beds         | Patients |
| 1913 | 570      | 562      | 507          | 568      |
| 1914 | 570      | 594      | 507          | 610      |
| 1915 | 570      | 595      | 507          | 631      |
| 1916 | 570      | 595      | 507          | 627      |
| 1917 | 570      | 694      | 507          | 675      |
| 1918 | 570      | 846      | 507          | 653      |

Total increase in patients between 1892 - 1918 = 1446

In order to obtain relevance from the above figures it is necessary to consider the simultaneous increase in population countrywide.

TABLE 2

SOUTH AFRICAN POPULATION CENSUSES 1865 - 1918

|           |                     | European | Non-European |
|-----------|---------------------|----------|--------------|
| Cape      | 1865 <sup>1</sup>   | 181,592  | 314,789      |
|           | 1875 <sup>2,3</sup> | 236,783  | 484,201      |
|           | 1890/1 <sup>5</sup> | 376,987  | 1,150,237    |
|           | 1904 <sup>6</sup>   | 579,741  | 1,830,063    |
|           | 1911                | 582,377  | 1,982,588    |
|           | 1918 <sup>7</sup>   | 618,825  | 2,132,110    |
| Natal     | 1890/1              | 46,788   | 497,125      |
|           | 1904                | 97,109   | 1,011,645    |
|           | 1911                | 98,114   | 1,095,929    |
|           | 1918 <sup>7</sup>   | 121,931  | 1,292,560    |
| Transvaal | 1890/1              | 119,128  | No figures   |
|           | 1904                | 297,277  | 972,674      |
|           | 1911                | 420,562  | 1,265,650    |
|           | 1918 <sup>7</sup>   | 499,347  | 1,544,151    |
| O.F.S.    | 1880 <sup>4</sup>   | 61,022   | 72,496       |
|           | 1890/1              | 77,716   | 129,787      |
|           | 1904                | 142,679  | 244,636      |
|           | 1911                | 175,189  | 352,985      |
|           | 1918 <sup>7</sup>   | 181,678  | 440,271      |

Statistics taken from the Censuses of Population 1865 - 1921.

- 
1. 1865. No figures for other colonies available.
  2. 1875. British Kaffaria annexed to Cape Colony between 1865, when previous census was conducted, and 1875.
  3. No figures for other colonies available.
  4. 1880. No figures for other colonies available.
  5. 1890/1. Griqualand West and Native Territories, excluding Pondoland, annexed between 1875, date of last complete census, and 1891.
  6. 1904. First simultaneous census of the colonies now comprising the Union. British Bechuanaland and Pondoland were added to Cape Colony between 1891, date of last census, and 1904.
  7. 1918. Non-European figures only available for 1921, none in 1918.

TABLE 3INCREASE IN THE POPULATION OF SOUTH AFRICA BETWEEN 1890 AND  
1918 SHOWN IN PERCENTAGES

|           |           | European | Non-European |
|-----------|-----------|----------|--------------|
| Cape      | 1890-1904 | 53.78%   | 59.10%       |
|           | 1904-1911 | 0.45%    | 8.33%        |
|           | 1911-1918 | 6.26%    | 7.54%        |
| Natal     | 1890-1904 | 107.55%  | 103.50%      |
|           | 1904-1911 | 1.03%    | 8.33%        |
|           | 1911-1918 | 24.27%   | 17.94%       |
| Transvaal | 1890-1904 | 149.54%  | No figures   |
|           | 1904-1911 | 41.47%   | 30.12%       |
|           | 1911-1918 | 18.73%   | 22.00%       |
| O.F.S.    | 1890-1904 | 83.59%   | 88.49%       |
|           | 1904-1911 | 22.79%   | 44.29%       |
|           | 1911-1918 | 3.70%    | 24.73%       |

Figures obtained from Censuses of Population 1865 - 1921



## Chapter VI

### Pre-Union Legislation Appertaining to the Insane

The present study has identified a gradual improvement in the standard of institutional accommodation provided for the allegedly insane in the Cape Colony. It has traced the establishment of asylums in Natal, the Orange Free State and the Transvaal (then also known as the South African Republic) throughout the latter half of the nineteenth century, and has noted the system of racial segregation in every institution. What is emerging is a perceived need by society to control the allegedly insane, but within that system to maintain a strict form of apartheid.

The purpose of the present chapter is to supply a comprehensive view of legislative acts during the nineteenth century. Incidents which may have precipitated these Acts will be discussed, together with the intentions and implications of such legislation. Any repercussions which followed the new laws will be considered.

Of particular interest will be any discernable movement in legislation which may indicate a shift in policy from the care and control of the insane towards one of treatment.

Copies of all the pre-Union laws which were accessible are included in the Appendix to Chapter VI.

#### a) The Legitimacy of the Certification of the Insane in South Africa during the Nineteenth Century

De Villiers (1972), and Minde (1974) both assert the process for certification of the insane in nineteenth century South Africa was highly questionable, but fail to specify the

principles on which such reasoning is based. Kruger (1980 p.12) asserts that Section 1 of the Cape Lunacy Act of 1879 was such that "A criminal act or attempt thereto was therefore required for admission."

It is the intention of the present writer that this section will examine all available legislation appertaining to the certification of alleged lunatics in the four main areas of South Africa in the second half of the nineteenth century. It had been hoped that all the legal documentation necessary for this research would be available as a primary source. Although the parliamentary acts under discussion were available, it was unfortunate that the circulars, also discussed, were not. It was therefore necessary to use a secondary source for this information.

It would appear that the earliest relevant legislative acts in South Africa appertaining to lunacy were the Cape Ordinances No.5 of 1833 and No. 3 of 1837. These followed Roman-Dutch Law whereby any person found to be insane was denied the right to possess any estate or property. No mention was made of the legal process necessary for the certification of the insane, these laws dealt solely with the property and estates of lunatics.

The inference is that property was considered of greater value than the allegedly insane person.

According to Kruger (1980) the procedure for certification of lunatics was first specified, not in an act of legislation, but in two circulars issued by the Colonial Secretary;

Circular No.28 of 1866 and Circular No.31 of 1885. (Kruger 1980 p.8) As already stated, verification of the contents of these circulars has not been possible, but Kruger (1980 p.8) asserts that they contained instructions to all resident magistrates on the requisite procedures for the admittance of a patient to an asylum:

"... Circular No.28 of 1866 was addressed from the Colonial Office to all resident magistrates. It instructed all resident magistrates in future to apply for authority to forward "any lunatic patient" to an Asylum on a form enclosed with the circular, on which the magistrate had to state the personal particulars of the patient as well as the duration of the existing attack, whether the patient is dangerous to others and the "cause of insanity, if hereditary." This form had to be accompanied by the medical certificates of two licensed medical practitioners..." Kruger (1980 p.8/9)

There would appear to be a certain amount of ambiguity in the wording of this document. The magistrates, to whom the circular was addressed, are instructed to "apply for authority to forward any lunatic patient to an asylum". One may only assume that such authority would be the Colonial Office.

The second circular, No. 1 of 1885, was, according to Kruger (1980 p.9), also sent to resident magistrates by the Colonial Secretary adjoining them to:

"...ensure that all "lunacy certificates" granted by practitioners be completed in accordance with circular 28 of 1866."

Kruger (1980) adds that no Cape law gave magistrates the right to "certify" patients in this manner, alleging that prior to 1866 lunatics were treated according to Roman-Dutch law.

It may be expedient, at this point, to briefly mention Roman-Dutch law appertaining to lunacy. At the time of Dutch rule in the Cape Colony the law required a court order to sanction the confinement of the alleged lunatic, but only after "the matter had been thoroughly investigated." Kruger (1980)

One may assume that the intention was for such investigation to be conducted by medical practioners, but nowhere is this specified.

The main focus of Roman-Dutch law relating to lunatics dealt with the appointment of a curator, either by the provincial court of Holland or by the ordinary magistrates (depending upon which court the relatives approached), to manage the affairs of the lunatic. The emphasis was solely on the property of the lunatic.

It would appear that Circular No.28 of 1866 was the first official document issued under British rule which specifically requested the production of medical certificates as a

prerequisite for the detention of lunatics in the Cape Colony. No reason could be traced to show why such an instruction was issued in a circular rather than promulgated as an Act of Parliament.

It is suggested that Circular No.28 of 1866 may have been issued by the Colonial Office as an interim measure. It has previously been mentioned that successive medical superintendents on Robben Island were complaining about patients being transported without the necessary certification of lunacy. de Villiers (1971). It may be that these complaints had gathered such momentum that the Colonial Office felt pressured into remedying the position. Although the legitimacy of the circulars remains in doubt, they may have been conceived as a stop-gap measure pending the promulgation of an Act of Parliament.

Although there were no mainland asylums in South Africa in the 1860s it is apparent that a need to legitimise the committal procedure is emerging. The first law appertaining to lunacy in Natal was promulgated two years later, in 1868.

By the time the second Circular, No.31 of 1885, was issued legislation requiring medical certification had already been promulgated in the form of the Cape Lunacy Act No.20 of 1879. In view of this one wonders why the second circular was deemed necessary.

Kruger (1980 p.8) asserts that the circulars of 1866 and 1885 referred to the detention of "any lunatic patient" in the Cape Colony, and he submits that such detention was

illegal because no such law had been promulgated by Parliament. It is necessary, at this point, to compare relevant acts from the four provinces and to attempt to assess the legitimacy they afford.

The Cape Lunacy Act No.20 of 1879 states in the preamble that it's purpose is to:

"make provision for the safe custody of, and the prevention of crimes being committed by, persons dangerously insane, and also for the care and custody of persons who are insane but not dangerously so".

This would appear to cover all categories of alleged lunatics, yet throughout its fourteen sections the Act fails to stipulate the procedure necessary for the committment of non-violent or non-criminal patient. Therefore it would appear that the detention of "plain" lunatics continued to remain unlawful in the Cape Colony.

It appears likely that this omission was the basis of the claim by a Member of Parliament, J.Molteno, that the laws were "so bad that two-thirds of the alleged lunatics were illegally detained". Hansard (16th July 1891) It is also suggested that this may have been the legal loophole used to obtain the release of two people who, according to Minde (1947b), challenged detention warrants issued for ordinary lunatics by magistrates in the Cape Colony.

The major point which emerges from the above information is that considerable doubt is raised over the legitimate certification of the alleged lunatics confined in Somerset Hospital or later on Robben Island. Not only is the legal power of the magistrates questionable, but the circulars also suggest a lack of certification by medical practitioners prior to 1866.

**b) South African Laws Appertaining to Lunacy 1868-1897**

**(i) Terminology**

Included below is a list of the terminology used to describe alleged lunatics in the legislative acts of the late nineteenth century. It will be noted that although numerous terms are used, only two, "lunatic" and "criminal lunatic", have been defined:

- a) a person of unsound mind;
- b) insane but not dangerously so;
- c) dangerously insane;
- d) dangerous lunatic;
- e) dangerous idiot;
- f) a "lunatic" includes any idiot or person of unsound mind incapable of managing himself or his affairs.

- g) a "criminal lunatic" means any person convicted of any crime and certified to be insane under the provision of this Act.

These laws do not define any parameters between insanity, lunacy and idiocy. It is not clear whether each term implied a different "category" of lunacy in the 1890s, or whether the terms were interchangeable. It will be recalled that in South Africa, by this time, white patients were being regarded as "curable" or "incurable". By 1916 idiocy was to be classified as the lowest grade of mental defective. One may wonder, therefore, if this term already denoted such a condition in the 1890s. It is also suggested that certain terms may, even before official classification, have denoted mental illness rather than mental retardation.

One feature of all the acts promulgated during the 1890s is the emphasis they place on the detention and on the confinement of lunatics regarded as either criminal, dangerous or violent.

Whereas the Acts of the 1830s concentrated on provision for the property of alleged lunatics, it is suggested that during the latter half of the century legislation changed course. It became overly concerned with protecting the public from lunatics considered to be either criminal, or to exhibit violent or dangerous tendencies. In each case it would appear that consideration for the welfare of the non-violent lunatics was not a high priority.



(ii) Detention Procedures

This section will begin with a summary of the detention procedures laid down in pre-Union legislation. This will be followed by a review of the rights of patients according to pre-Union legislation, and the section will end with a summation of the shifts in perception as reflected in the acts between 1868 - 1897.

With a few exceptions the detention procedures would appear to differ little throughout South Africa over the final thirty-two years of the nineteenth century.

Natal Act No.1 of 1868 and Cape Act No.20 of 1879

Upon application by a relative (or in the Natal Act of 1868, by a member of a Society), persons indicating derangement of mind and a purpose of committing suicide, or manifesting an intention to commit any crime or offence could be detained.

A magistrate's signature on the warrant, plus two signed medical certificates, was required for detention in a place of safe confinement for an unspecified period. Following this, the signature of either Governor or Colonial Secretary, plus two signed medical certificates was required for committal to asylum.

Orange Free State Act No.4 of 1893 and Transvaal Act No.9 of  
1894

Procedures much the same as the earlier Cape acts, but with one minor inclusion. This relates to persons found wandering at large. In both the Orange Free State Wet No.4 of 1893 and the Transvaal Wet No.9 of 1894, provision is made for the detention of "persons found wandering at large deemed to be dangerous". The procedures were to be the same as those mentioned above.

Cape Acts No.35 of 1891 and No.37 of 1897

Detention procedures in both acts remain as for the 1879 act. with the following additions in Act No.37:

Provision was now being made for the admission of urgent cases.

The reference to potential suicides has been omitted.

A constable was empowered to apprehend and convey to prison or hospital an alleged lunatic if it was judged necessary for public safety or for the welfare of the alleged lunatic. No person shall be so detained without the knowledge and authority of a magistrate for more than twenty-four hours.

It was declared unlawful for any person with a financial interest in the affairs of the alleged lunatic to sign the necessary forms, although a family member or friend could legally do so.

(iii) Provision for Confinement of Lunatics

Natal Act No.1 of 1868

Legal provision for detention of all lunatics whether violent or non-violent.

Cape Act No.20 of 1879

No legal provision for lunatics other than those declared dangerous.

Dangerous lunatics confined in prison or place of confinement. Transferred to asylum on warrant from Governor or Colonial Secretary. Convicts under sentence of death found to be insane detained in asylum by order of the Governor.

Cape Act No.35 of 1891

This act is in five parts, the relevant sections being Parts II and III. Part II refers to criminal lunatics, while Part III includes the first mention in Cape law of the procedures referring to lunatics not being dangerous or criminal.

Basic provisions are the same for both categories, and remain fundamentally unchanged from the Cape Act of 1879.

Orange Free State Act No.4 of 1893; Transvaal Act No.9 of 1894  
Cape Act No.1 of 1897

Practically verbatim of Cape Act no 35 of 1891. Provision for confinement remains.

(iv) Rights of Patients

Natal Act No.1 of 1868 and Cape Act No.20 of 1879

**Release clause if soundness of mind is regained by potential suicides.**

**Release clause if criminal offender regains soundness of mind. If sentence is complete release follows immediately, if incomplete offender transferred to gaol for remainder of sentence.**

**All patients entitled to reasonable visiting rights from families, friends and legal advisor.**

**Official visitor appointed by Governor to visit asylums and ensure rights of patients.**

Acts for all Territories during the 1890s

**Annual report on each patient was required from asylum.**

Lunatics in custody of family or friends may be removed to asylum if found neglected or maltreated.

Release clauses for those no longer of unsound mind as in 1879 Act.

Penalty to be imposed on anyone lodging a lunatic except under the provisions of this Act.

Penalty to be imposed on anyone ill-treating, neglecting or having carnal knowledge of a patient in an asylum.

Penalty also imposed on anyone assisting with escape from an asylum.

Any patient escaping from an asylum and remaining at large for twenty-eight days to be granted his freedom. (Cape only)

No male person in an asylum shall have the personal custody of a female patient.

Mechanical means of bodily restraint shall only be applied for the purpose of surgical or medical treatment.

(v) Costs of Transfer and Maintenance of Patients

Acts for all territories practically verbatim - unchanged between 1868 and 1897.

All costs initially paid by Government on condition that such money is recovered from estate of lunatic where possible.

(vi) Alternative AccommodationNatal Act No.1 of 1868 and Cape Act No.20 of 1879

These acts allowed lunatics to be cared for by family or friends. This ruling applied also to dangerous lunatics, providing their relative or friend entered into sufficient recognizance for his peaceable behaviour, safe custody and proper treatment.

Cape Act No.35 of 1891; Orange Free State Act No.4 1893;  
Transvaal Act No.9 of 1894

Initial warrant issued by magistrate now referred to as Summary Reception Order. Patients detained under this order may be cared for by family or friends as in the Cape Act No.20 of 1879.

Families now given the right to apply for an enquiry into the state of mind of any detained patient.

The Colonial Secretary has the right to transfer patients to an alternative asylum. (Cape only)

Cape Act No.1 of 1897

Practically verbatim with the earlier acts, with the following inclusion:

"The Colonial Secretary is empowered, on payment of a fee, to grant a licence to keep a house for the reception of more than one lunatic."

(vii) Voluntary AdmissionCape Act No.1 of 1897

Patients whose mental condition is not such as to justify the issue of certificates of insanity may be admitted to an asylum as a voluntary patient, provided they make written application and have written assent from the Colonial Secretary.

(viii) Cases of UrgencyCape Act No.1 of 1897

Where it is expedient either for the welfare of a person alleged to be a lunatic or for public safety, such a person may be received and detained in any asylum upon an urgency order made (if possible) by the husband or wife or by a relative, accompanied by one medical certificate.

(ix) Provision for Property of LunaticsAll Acts Between 1868 and 1897 Practically Verbatim

A Curator to be appointed by the court.

Such curator must provide the court with an inventory and may be empowered by the court to sell or to raise a mortgage on the property if it is in the interest of the lunatic.

(x) Procedure when Persons on Board Ship become InsaneCape Act No.1 of 1897

Should any passenger or crew on board any vessel entering any port in the Colony be deemed idiotic, insane or imbecile and as such is thought to become a charge for the public, then the owner, charterer, agent or master is required to enter sureties as stipulated by a magistrate. Failure to do so will result in that person being returned to the vessel.

(xi) Indemnity ClauseNatal Act No.1 of 1868; Cape Act No. 20 of 1879

All persons who may have subjected themselves to any penalty, or indictment by ordering or being concerned in the care or custody of persons, who may, prior to this Act, have been committed to prison or confined in any gaol or hospital by the authority of a magistrate are hereby indemnified, freed and discharged from all penalties, actions, indictments and liabilities incurred by reason of the confinement of such persons.

c) Summary of the Shifts in Perception as Reflected  
Nationally in the Acts Between 1868 - 1897

This summary will illustrate what appears to be a changing attitude in the legislative approach to the care and control of the insane in the final quarter of the nineteenth century.



The Natal Act No.1 of 1868; the Cape Acts No.35 of 1891 & No.1 of 1897; the Orange Free State Act No.4 of 1893, and the Transvaal Act No.9 of 1894 all made provision for the legitimised procedure under which non-criminal and non-violent lunatics could be detained. This was in addition to the procedure to be followed for the detention of criminal or violent lunatics. The one act which appears to make no provision for non-violent lunatics is the Cape Act No.20 of 1879.

Kruger (1980 p.17) describes the Natal Law No.1 of 1868 as "practically verbatim the Cape Act No.20 of 1879". He mentions briefly that Sections 6 and 7 of the Natal Act were "not taken up in the Cape Act". The present writer would suggest that these sections, quoted below, are too important in the argument on the legitimacy of "plain" lunatics to be summarily dismissed. The relevant sections are quoted below:

"Section 6. The Lieutenant Governor may, on the application of one or more of the relatives or guardians of any insane person (which application shall be sanctioned in writing by one of the Judges of the Supreme Court or by a Resident Magistrate): and on receiving the certificate of two medical practioners that they have examined and found such person to be of unsound mind, order and direct, if he think proper so to do, that such person be received into and kept in custody in such a lunatic asylum as he may from time to time appoint."

"Section 7. When it shall appear to the Judge or Resident Magistrate to whom any such application shall be presented that an insane person has no relative or guardian within the Colony, or none accessible without convenient delay, any person or society under whose protection or care such insane person shall actually be for the time being shall, for the purposes of the preceding section, be deemed the guardian of such insane person: and it shall be lawful for such Judge or Resident Magistrate to cause the applicant, and any other person in his discretion, to be examined as to the facts in every case, on oath; any wilfully false answer by any such applicant or person thereupon given shall be deemed perjury, and punishable as such."

Quite clearly these sections refer to persons allegedly insane, but who are neither violent nor criminal. It would appear that by 1868 the committal procedure for "plain" lunatics had been legitimised in Natal, if not in the Cape Colony.

Legislation in the Transvaal and in the Orange Free State did not follow until 1890s. The Orange Free State Ordinance No.4 of 1893 and the Transvaal Wet No.9 of 1894 followed the line of the Natal Act of 1868, making provision for the legal detention of "those insane who are not dangerous nor criminal". Such persons are defined as "not in control of himself or his affairs".

Prior to the 1890s all acts afforded patients limited rights. Whilst they were granted, in theory, visiting rights parallel to those of criminals in gaol, in practice those on Robben Island (which in 1879 would appear to be the majority of lunatics in the Cape Colony) were at a considerable disadvantage. Friends and families wishing to visit convicts in the mainland gaols may have had lengthy journeys, but these could in no way equate with the arduous and at times perilous journey to Robben Island. It should be noted that the distance between Robben Island and the mainland before the infill of the harbour at Cape Town was fourteen kilometres, considerably further than it is today. de Villiers (1971). One must wonder how many of those transported to the Island ever saw their families, friends or indeed their legal advisers again.

All the acts, with the exception of the Cape Lunacy Act No. 20 of 1879, make provision for a curator to deal with the estate of detained patients. The Transvaal Act of 1894 differs from the other Acts by appointing such a curator not only to safeguard the estate of the alleged lunatic, but in respect of his person. For the first time a College of Curators is mentioned here, but the term is not defined. The indications are that this was a professional body, rather than an academic institution. It would appear that a Curator from this College was to be appointed to each asylum.

"The Curator of the asylum must testify in an application by one or more of the carers involved with the insane person (which application must be

verified by a local authority) and by the evidence of two doctors' certificates ...that to the satisfaction of the curators the person involved has been examined and found to be insane and has thus been taken into the custody of the institution."  
(Translated from High Dutch)

It is also worth noting that this Transvaal act refers to the custodians of the lunatics as "carers". This is the first appearance of this term. Previous acts have referred to them as "lunatic keepers". It may be that the change in terminology denoted a changing attitude, or it may be that this was the closest word to "keepers" in the High Dutch language.

With regard to the clause relating to "persons found wandering at large deemed to be dangerous" in both the Orange Free State Act No.4 of 1893 and the Transvaal Act No.9 of 1894, it is suggested that by the 1890s vagrancy was becoming a problem in those areas. It would appear likely that the proximity of Transvaal goldfields attracted considerable numbers of vagrants, hence the Pretoria authorities found it either necessary or convenient to have Act No.9 promulgated. If a vagrant was certified, rightly or wrongly, as being a dangerous lunatic, it appears likely that he would be detained for a considerably longer period than if the police courts had gaoled him on a vagrancy offence.

Although Kimberley, the centre of the initial diamond diggings, is technically in the Cape, it is so near the Orange Free State border that it is felt the same argument may also

apply here. It is suggested that the impact of vagrants wandering to and from the diamond diggings would be more strongly felt in Bloemfontein, (the administrative centre of the Orange Free State) 180 kilometres from Kimberley, than in Cape Town, nearly one thousand kilometres away.

It would appear that one of the few humanitarian aspects of the pre-Union acts was the stipulation that the Governor appoint an official visitor to report on any patient reputed to have regained soundness of mind. Should such a finding be verified by two medical practitioners then the patient was to be released forthwith. Should the patient be under sentence for a criminal offence he would only be released if he had completed the sentence, otherwise he would be transferred to a gaol for the remainder of the sentence.

However, it is noted that the above clause refers to only two class of lunatics, namely the criminal lunatics and the potential suicides. It would appear likely that such patients would have been the mentally ill rather than mentally handicapped. Upon their presumed recovery they were released, while no such reprieve was possible for those who would nowadays be regarded as mentally handicapped.

While it is not totally unexpected to note that the Natal Act No.1 of 1868 and the Cape Act No.20 of 1879 make provision for lunatics to remain at home, cared for by family or friends, it is somewhat surprising to discover that this clause applied equally to "dangerous lunatics and dangerous idiots". This would only apply if:

"his friend or relative shall enter into sufficient recognizance for the peaceable behaviour, safe custody and proper treatment of such dangerous lunatic or idiot before a Resident Magistrate or one of the Judges of the Supreme Court."

One can only theorise on the reasoning behind allowing allegedly dangerous lunatics to be returned to the custody of their families. One may wonder whether it was for humanitarian reasons, or whether it was a means of freeing the asylum authorities from the responsibility of confining certain difficult patients whose families were willing and able to care for them. When one considers that the predominant focus of this act was on control of lunatics and the protection of the public such an action appears to be contrary to normal procedure. One can only ponder at the reaction of the public when faced with a lunatic, hitherto classed as dangerous, being released into their midst in cognizance of his family.

It is suggested that the most revealing clause in the Natal Act No.1 of 1868 and the Cape Act No.20 of 1879 must surely be the indemnity clause. The implications of this clause are such that it is quoted here in full:

"All persons who may have subjected themselves to any penalty, action, or indictment by promoting, ordering, or being in any way concerned in the care, charge, or custody of persons, who may, before the time at which this Act shall take effect, have been committed to prison

or put under confinement in any gaol or hospital by the authority of any Magistrate or Judge, or of the Governor, as dangerous lunatics, or who having been charged with or convicted of some crime or offence, have been confined as insane persons, shall be, and hereby are, indemnified, freed and discharged from all penalties, actions, indictments and liabilities which may have been incurred by reason of the confinement of such persons; and all such persons who at the date at which this Act shall take effect shall be under such confinement, are hereby declared to be subject to the provisions of this Act so far as the same may be applicable."

Cape Lunacy Act No.20 of 1879 section 12.

(Natal Act No.1 of 1868 section 14 practically  
verbatim)

The unmistakable inference from this clause must be that the legality of committal orders prior to these acts had been highly questionable. As stated earlier, no traceable evidence has been found to establish the authority on which the Governor or the Colonial Secretary in the Cape Colony, nor in Natal, signed such orders.

Not only does this clause grant indemnity to those involved in any wrongful committal, but it offers amnesty to those "in any way concerned in care" of patients. Presumably those guilty of maltreatment prior to the 1879 Act would be exempt from prosecution.

The number of persons, officials or lay persons, who benefitted from this indemnity clause, will unfortunately never be known.

The claim made in parliament that "...two-thirds of the alleged lunatics were illegally detained" Hansard (1891), has been quoted earlier. One must now ask whether the alleged lunatics were being wrongfully detained because the signatories of the warrants were not lawfully empowered to act in this capacity, or whether the patients were not, in fact, of unsound mind. If the latter were the case it would be reasonable to assume that these acts, the Natal Act No.1 of 1868 and the Cape Act No.20 of 1879, might result in the re-assessment of many patients confined as lunatics. From the sparse records available it has not been possible to identify a meaningful deduction in patient numbers.

There is only one mention of any such re-evaluation. Foster (1990), without quoting his source, states that two people successfully challenged detention warrants issued by ordinary magistrates in the Cape Supreme Court. Although Foster quotes no date for this incident it would appear to have taken place some considerable time after the promulgation of the 1879 Act because he asserts that this action resulted in the repeal of the act. The Cape Act No.20 of 1879 was only repealed in 1891, when it was replaced by a later piece of legislation.

In summation, the purpose of both the Natal Act No.1 of 1868 and the Cape Act No.20 of 1879 was to allegedly legitimise the confinement and control of lunatics while protecting the



public from those regarded as dangerous or having criminal intent. It would appear that only the Natal act legally empowered the committal of "plain" lunatics.

The rights of those in asylums, as laid down in these acts, were negligible, while those responsible for their committal were absolved from any blame, should unlawful action be proved. It is abundantly clear where society and the lawmakers placed their priorities.

There appears to be no clear reason for the proliferation of official documentation dealing with lunacy in the Cape Colony between the issue of the first of the two circulars in 1866 and promulgation of the final pre-Union Act of Parliament in 1897. No record of public interest or pressure could be traced. A contemporary writer of the period, Wilmot (1869), in his History of the Colony of the Cape of Good Hope, makes no mention of lunatics, either in Somerset Hospital nor on Robben Island. Attention of both the government and the informed public in the Colony during the second half of the nineteenth century appears to have centred more on border conflict, than on the condition of the insane.

It was suggested earlier in this study that complaints from the medical superintendents of Robben Island may have drawn the attention of the Colonial Office to the need to legalise the procedure of committing the so-called lunatics. According to de Villiers (1971) patients were being sent to the Robben Island asylum without the documentation authorising committal. The basis for such complaints is unclear. There is nothing to

indicate whether the documents arriving with the patients were invalid because they lacked legal authorisation or whether the certification by two medical practitioners was omitted.

The Cape Lunacy Act No.35 of 1891 was an altogether more comprehensive document than the act of 1879. It consisted of sixty-seven sections as against fourteen sections in the previous act. One of the major differences is the legitimising of the procedure for the detention of "lunatics not being dangerous or criminal", thus rectifying the omission in the 1879 act.

By the 1890s the acts countrywide are revealing an emerging pattern of safeguards for the lunatics and penalties for their custodians found guilty of malpractice. By making it illegal for anyone to detain a lunatic in an asylum, or for board and lodging, except under the provisions of these acts, the law was ensuring that, theoretically, all inmates of asylums had been legally certified. In addition it was illegal for any person to detain an alleged lunatic in a private dwelling for profit unless the said lunatic had been legally certified.

Each of the four major territories had legalised the admission of "plain" lunatics, in addition to those allegedly violent or criminal.

Attention was also given to the appointment of curators for any persons detained under the later acts. Curators, both curator ad litem and curator bonis, had featured prominently in Roman-Dutch law under the rule of the Dutch, but only as custodians of the property of the alleged lunatic. Although

the British continued to apply Roman-Dutch law, no mention was made of the appointment of curators in either the Natal Act of 1868 or the Cape Act of 1879. By the 1890s the appointment of curators was again a legal requirement when a patient was detained, but now the curators were empowered to appeal on behalf of a lunatic allegedly committed unlawfully to an asylum, in addition to being entrusted with control over his property.

Legislation countrywide gave a magistrate the authority to detain an alleged lunatic for the period of one month under a summary detention order. This is viewed as an important inclusion, which theoretically at least, would allow time for more thorough investigation of the patient's case before committal was authorised.

A change of emphasis is already detectable in the legal documents. Whereas the earlier acts concentrate almost exclusively on dangerous or violent lunatics, the later acts are focusing on those allegedly insane, but non-violent.

While the emphasis in the Cape Act No.20 of 1879 was largely on the protection of the public from the lunatic, the acts of the 1890s focus rather more on the care of the lunatic himself.

Although the rights of the patient remain limited certain safeguards are emerging:

- a) The time an alleged lunatic may be held under a summary detention order was restricted to one month.

- b) An alleged lunatic, apprehended by a constable, either for the safety of the public or for his own welfare, could not be detained for longer than forty-eight hours without the knowledge or authority of a magistrate.
- c) Any allegedly insane person found to be neglected or cruelly treated by family or guardian could be legally removed and placed in an asylum.

It has not been possible to trace the extent to which lunatics were held in private dwellings in any of the territories during the latter half of the nineteenth century nor, until the promulgation of the Cape Act No.1 of 1897 was there any traceable record of the private madhouses reminiscent of those in England.

However, it has been stated earlier that this act contained a clause allowing the Colonial Secretary "on the payment of a fee (to grant a licence) to keep a house for the reception of more than one lunatic". No traceable evidence has been found to substantiate the location of these premises nor to establish their prevalence, although the inclusion of such a clause would appear to suggest they were relatively numerous. The size of such establishments and social status of their patients would be of considerable interest. It may be remembered that their English counterparts catered for both the parish paupers and the middle-classes.

Not only were patients safeguarded against unlawful detention by the 1890s acts, but those inside the asylums and those in the custody of families or private establishments were both afforded a degree of protection against neglect, ill-treatment or sexual abuse. Furthermore, the families of patients confined in asylums were given the right to instigate an enquiry into the legality of their detention.

A major move towards more humane care of the allegedly insane was the abolition of any mechanical means of bodily restraint except "if necessary for the purpose of surgical or medical treatment", in the Cape Act No.1 of 1897. A medical certificate had to be supplied before the use of such restraint and the grounds for the application were to be detailed thereon. A record of the use of such restraint was required to be kept.

No similar move was evident in the legislation of other territories for that period, consequently it is not clear when they followed the action of the Cape.

It would also appear that the Cape was the only territory during the 1890s specifying that the superintendent of an asylum should provide the Colonial Secretary with a report on every patient "not less than once a year"

The provisions for patients detailed above reveals a distinct progression towards a more humanitarian approach in the legislation appertaining to lunatics. Their rights remain severely limited, but there is a visible trend towards the

recognition of such rights. No longer, at least in theory, were patients at the mercy of the asylum staff; they could not be manacled, chained, or restrained in straitjackets. Above all, patients could not be confined without legal certification and, if there was cause to doubt, their families had recourse to appeal on their behalf.

It is debatable whether the clause granting greater powers to the curators of property belonging to lunatics were beneficial to the patients or not. It was declared legal for the curators to mortgage, sell or lease out property necessary to provide for the maintenance of the lunatic. While in theory this law may have been regarded as a financial necessity to cover costs, it may, of course, have been open to abuse. The law also allowed for curators to be paid for their duties and to deduct such payments from the estates of the lunatics.

The Cape Act of 1897 contains two important clauses covering new categories of admission. One was the provision for the admission of voluntary patients and the other allowed for emergency admissions. The voluntary patient clause applied to any person "who is desirous of voluntarily submitting to treatment, but whose mental condition is not such as to justify the issue of certificates of insanity." The inclusion of such a clause illustrates the changing approach to mental health which had been taking place in the asylums of the Cape Colony. Not only were the asylums treating patients rather

than simply confining them, but the fact that patients would voluntarily enter an asylum is an indication that such treatment was being recognised as effective. Once again South African asylums were coming into line with their European counterparts.

The emergency admission clause provided, for the first time, legitimate admission of urgent cases to asylums. In such circumstances the urgency order had to be made (if possible) by the husband or wife and be accompanied by one medical certificate.

The Cape Act of 1897 contains the earliest allusion in the Cape Colony to provision for "an idiot or imbecile from birth or from an early age". Although official categorisation was not to follow until 1916 this act was clearly laying the foundations in distinguishing between lunatics and idiots or imbeciles. It states that such persons may be placed by parents or guardian in "such an institution as the Colonial Secretary may appoint, for the care, education and training of idiots or imbeciles". Here we have the first indication of education or training being legally perceived as a need of the mentally handicapped. Unfortunately it would appear that such provision was theorised rather than implemented.

Throughout this study very little reference has been traced to children among the allegedly insane. The assumption is that, for the most part, children who today would be termed mentally handicapped, would remain within the care of their families or communities, no matter how severe their handicap.

Only in two cases was there tracable reference to children in asylums. The first was in the records of Town Hill Hospital, where it was reported that eight children were among the patients in 1898. Town Hill Hospital Centenary Brochure 1880-1986. It would appear that only custodial facilities were available in this instance.

The other situation appears to have been somewhat different in that it offered the first recorded attempt in South Africa to provide training and education for children in an asylum. According to a report by the Physician-Superintendent of Grahamstown Mental Hospital, Dr.A.Cowper, (cited in the report of the Commissioner in Mental Disorders 1918 p.20) in 1894 a new block was added with the intention of it being used as:

"a home for the training and education of the milder types of imbeciles and feeble-minded and backward children. A Lay Superintendent and his wife were put in charge but the cases received became more and more of a hopeless kind till attempts at training became a work of supererogation and the lay superintendency was abolished and the care of the children devolved on the ordinary female nursing staff."

The inference is that the attempts at training and education were thwarted by the admission of children who would today be classed as moderately or severely handicapped, and by the shortage of staff qualified to train or teach such children.



No further mention of such a scheme could be traced until the second decade of the twentieth century, when the focus of concern was on the feeble-minded. This will be discussed in a subsequent chapter.

The final clause of the Cape Act of 1897 deals with a problem which appears to have relevance only to that Colony, and then with those visiting her shores rather than her citizens. One must assume the prevalence of insanity among seamen (or passengers) to have been considerable for it to necessitate legislation. Obviously if the incidence of such cases was high a considerable burden would have been placed, not only on the citizens, but on the already overcrowded asylums. It would appear that this was no new problem because mention was made of seamen becoming patients in Somerset Hospital when Bailey distributed his prospectus in 1818. When one considers the conditions on board ship, the dietary restrictions and the length of the voyages during the nineteenth century it would be reasonable to expect a high rate of mental illness.

This chapter has traced pre-Union legislation over the latter half of the nineteenth century. It noted the changing perception of the insane from the first circular of 1866 in the Cape Colony which virtually reiterated the certification process established under Roman-Dutch law, to the final Act of the century which afforded the insane some measure of protection from unlawful committal, ill-treatment and mechanical restraint. Voluntary admission to the asylums was provided for, as were emergency admissions. The first

experimental centre for the education or training for children born idiot or imbecile was established, and although this was not a success it pointed the way for future educational or training policies for the mentally retarded.

Chapter VII will discuss the legislation appertaining to the insane promulgated in the immediate post-Union years and consider the patterns which emerge. The study will concentrate on three acts in particular, namely The Lunacy and Leprosy Act No.14 of 1914; The Girls and Mentally Defective Women's Act No.3 of 1916 and The Mental Disorders Act No.38 of 1916.

Chapter VIIPost-Union Legislation Appertaining to the Insane:The Lunacy and Leprosy Laws Amendment Act No.14 of 1914The Girls and Mentally Defective Women's Protection Act No.3  
of 1916The Mental Disorders Act No.38 of 1916

Chapter VI identified a number of discernible shifts in the management of lunacy. The certification of patients was legitimised in Acts of Parliament throughout the four main territories between 1868 and 1897. Although the rights granted to allegedly insane patients were minimal, these late-nineteenth century laws went some way towards offering a degree of protection against unlawful committal, ill-treatment, mechanical restraint and sexual abuse.

While no official distinction was made in the acts between mental illness and mental handicap, or between the differing degrees of mental retardation, there were signs that such a classification system was, in practice, beginning to emerge. Patients were being segregated into different hospitals according to whether their condition was regarded as curable or non-curable. In the case of the former, the function of the mental hospital would appear to have changed from a purely custodial role to one which offered remedial treatment.

It was also noted in the previous chapter that in 1894 the first attempt to establish a centre for the training or

education of children with mild mental defects was instigated at Grahamstown. Although this venture was to be unsuccessful, apparently due to inexperienced and unqualified staff, it was an indication that such a need was being recognised.

Chapter VII will examine post-Union legislation in an attempt to discover whether these shifts in emphasis were maintained after 1910. (It was not felt necessary to include copies of post-Union laws in an appendix, as with pre-Union legislation, because these are more easily accessible.) Attempts will be made to detect any meaningful changes in the terminology of successive acts and the writer will endeavour to establish whether the improvements noted above were consolidated after the territories were joined at Union. The central focus of the discussion will be the implications and conceivable repercussions of the earliest post-Union laws rather than an analytic discussion of their content.

While a discussion on the political ramifications which led to Union are beyond the scope of this study, it is felt that certain points might be mentioned, because of their bearing on issues later raised in this work.

Following the end of the Anglo-Boer war in 1902 Alfred, Lord Milner, High Commissioner in South Africa and Governor of the Conquered Boer colonies, embarked on a policy of "Anglicisation" in South Africa. This included attempts to divert the Boers from their narrow, insular nationalism, and to inculcate Boer school children with the values of imperialist Britain. These attempts ended in failure, and on 31st. May 1910, eight years to the day after the Boer generals

had signed the surrender of the republics to the British Empire, General Louis Botha became the first Prime Minister of a united South Africa. This was the beginning of political power for the Afrikaner. (Illustrated History of South Africa, 1988)

Although Milner failed in his endeavour to "Anglicise" South Africa, he was more successful in another of his aims, that was to establish the political superiority of the whites. This aim, acceptable to both the Boers and the British, was made clear in a speech made by Milner in 1903, when he stated,

"A political equality of black and white is impossible. The white man must rule, because he is elevated by many, many steps above the black man; steps which it will take the latter centuries to climb, and which it is quite possible that the vast bulk of the black population may never be able to climb at all."

(Illustrated History of South Africa 1988 p.266)

This belief was to permeate not only South African politics, but every aspect of the social and economic structure of the country for almost a century.

It should be made clear, before embarking on an examination of the post-Union acts, that at Union in 1910 the laws and institutions affecting the insane in all four provinces were placed under the administration of the Minister of the

Interior. Foster (1990) It was this arrangement which enabled the promulgation of Act No.14, discussed below, to apply nationwide.

a) The Lunacy and Leprosy Laws Amendment Act No.14  
of 1914

The first noticeable fact about this piece of legislation is that it appears to apply equally to lunatics and lepers. Although these two distinct categories of patient had been housed in adjacent accommodation in both Somerset Hospital and on Robben Island during the nineteenth century, no previous legislative acts had included the mention of lepers.

It is not the purpose of this study to research into the societal perception of leprosy, in either the nineteenth nor the early twentieth centuries, but generalised reading, de Villiers (1971) and Burroughs (1958), creates the impression that the biblical concept of lepers as "unclean" continued to be perpetuated to a certain extent throughout that period. No doubt fear of contagion prompted this attitude and thus lepers continued to be regarded as social outcasts, housed in colonies as far as possible from the habitat of the general population.

As mentioned earlier, Vitus (1987 p.116) asserts that as late as 1920 lunacy and feeble-mindedness were "both conditions considered to be hereditary as well as contagious."

Vitus does not quote the source of this information, and the present writer has found no evidence to support the contention that lunacy was considered contagious in the twentieth century.

If Vitus is correct, then the reason for the inclusion of lunatics with lepers in the same act of legislation is understandable. However the present writer feels there is reason for doubt. The work of other writers, Scull (1987 & 1989) and Skultans (1979) among them has been researched without similar assertions being traced. However, there appears no doubt that lepers were regarded as social outcasts well into the twentieth century, and for legislators to group the two conditions together under this law may have had a detrimental effect on the public perception of lunacy.

The purpose of Act No.14 of 1914 was to allow transfer of patients across provincial borders. Although this Act is regarded by Foster, (1990) as a minor piece of legislation, it will be argued that it may have had serious repercussions. The act gives authority for:

- a) the recognition of warrants in all other provinces
- b) transfer of any patient from one institution to another established for like purposes in any part of the Union

One may assume the reason for the promulgation of Act No.14 was to alleviate congestion in overcrowded mental institutions and to allow a more even distribution of patients throughout the Union. Theoretically this law is exemplary, yet issue must be taken on two points.

An anomaly would appear to exist. The reports of Medical Superintendents of individual asylums are included with the

annual report of the Commissioner in Mental Disorders for 1918. Each record alludes to the necessity of this legislation in order to obviate overcrowding, yet the statistics quoted in these same documents fail to indicate any such transfer. (Reports of Superintendents of State Asylums included in the 1918 Report of the Commissioner in Mental Disorders.)

In Table I in the addendum to Chapter V statistics covering the period 1913-1918 are cited. At no time is there evidence of a meaningful decrease in patients at one institution and a corresponding increase at another asylum across interprovincial boundaries. If the purpose of this legislation was to alleviate overcrowding one would expect sizeable numbers of patients to be transferred in the immediate post-1914 years.

The one institution showing any decrease in patient numbers is Fort Beaufort, when in 1916 a reduction by thirty-seven patients was recorded. This would correspond with the return of black patients to Grahamstown asylum as a labour force.

The only other noteworthy movement in patient numbers was the transfer of fifty-four Europeans from Robben Island in 1915, destination unspecified.

There was a certain fluctuation in patient numbers at Port Alfred where statistics show an increase of twenty-nine patients in 1915; a decrease of thirty-three in 1916 and an increase of nine in 1917.



If the official statistics are correct no significant numbers of patients were transferred. Consequently the Act did little to obviate the congestion in any of the asylums and one might conjecture as to the purpose it served.

It has been noted in the previous chapter that unofficial classification of patients was already in operation in the Cape at the close of the nineteenth century. Socially constructed categories determined the placement of patients in the following instances:

- a) Valkenburg accepted only white patients regarded as curable.
- b) Black patients were removed from asylums designated for Europeans only.
- c) Port Alfred was considered unsuitable as an asylum, yet continued to house chronic black patients.
- d) European patients considered incurable were transferred to inferior accommodation at Fort Beaufort, where formally only non-European patients were housed.

The removal of black patients (b) occurred prior to the passing of the 1914 Act, and was not, as far as could be ascertained, across provincial borders.

The present writer would suggest that the main purpose of Act No.14 of 1914 was to facilitate the transfer of individual

chronic patients, i.e. those considered to be least desirable, across provincial boundaries and to legitimise two specific asylums, Port Alfred and Fort Beaufort, solely for the use of incurable patients nationwide.

"Incurable" in the early twentieth century would suggest low functioning defectives. By legalising transfer of patients across provincial boundaries the newer institutions throughout the country could purge themselves of their least desirable patients who were then removed to the decrepit accommodation at Port Alfred and Fort Beaufort. The number of these patients was likely to be small enough to escape notice in the statistics, where allowance has always to be made for reduction by natural attrition.

It is also suggested that low-functioning mental defectives would not be in a position to complain about the apparently appalling conditions of either asylum. Furthermore, as a generalisation, the families of chronic long-term patients are the least likely to have maintained contact, therefore complaints from that source were unlikely to arise.

Personal research at The Towers Hospital, Leicester, England, in the early 1970s revealed a pattern with regard to family visits to long-term patients. Patients who had been committed in their youth during the 1920s had usually received one or two parental visits shortly after admission. For some patients these were the last visits they were to receive.

Correspondence written to the institution by families revealed two main reasons for the discontinuance of visits:

- (a) a deep sense of shame and stigma at having a family member in an asylum.
- (b) a real or imagined conviction that the patient failed to recognise them, or to be aware that they had visited.

The way many families handled this situation was to forget that family member existed.

For some patients family visits continued, invariably from parents rather than siblings, at ever lengthening intervals until they ceased completely.

A few long-term patients were luckier and continued to retain family contact, with siblings taking over the visiting when they reached adulthood, particularly as parents became infirm or died. Unfortunately by the time of this research in the early 1970s most of the siblings of patients committed during the 1920s had themselves died or become too infirm to continue visiting on a regular basis.

Interviews and observations at the Midlands (Umgeni) Institute, Natal, South Africa, during the 1980s/90s revealed a similar pattern, with long-term low-functioning defectives being the most likely to have lost family contact. This applies equally when the patients concerned are admitted as

children. It was still not unusual for parents to report that the advice of the medical profession at the time of the child's birth was to "put the baby in an institution and forget it".

Based on these findings it is suggested that the long-term patients in both Fort Beaufort and Port Alfred would have maintained little or no family contact, and that their living conditions would go unquestioned.

The above comments are made on the assumption that the official statistics on which Table 1 was based were accurate. If these figures were incorrect and considerable numbers of patients over a broader spectrum than the long-term, low functioning retardates were affected, then a further issue, that of accessibility of asylums, should be raised.

It has already been stated that, overall, the family contact maintained with long-term patients is tenuous at best. It is suggested that transference of patients on an inter-provincial basis, as sanctioned by Act 14 of 1914 could only exacerbate these problems. Bearing in mind the distances involved in South Africa and the lack of available transport, for many families, any such transfer could only intensify the difficulty of maintaining contact between patient and family. Asylums are invariably sited far from urban centres making visits arduous and expensive for families and friends of the patients.

During the research at the Midland (Umgeni) Institute the case of a patient transferred from Cape Town to Howick, a

distance of almost 1,600 kms., came to light. The reason for the transfer remains unclear, with the hospital maintaining the patient had no family and therefore the distance was immaterial. Even after several years, the patient continues to feel uprooted and bereft of the friends he had made in the Cape institution where he previously lived. It is suggested that legislation which results in this added trauma illustrates a lack of understanding on the part of those in authority.

In Chapter VI it was suggested that the granting of equal visitation rights in 1879 to both convicts in mainland gaols and lunatics on Robben Island was of little avail to the latter because of the hazardous nature of the journey to Robben Island.

The present section of Chapter VII has discussed the transfer of both leper and lunatic patients across inter-provincial borders which was legalised by the 1914 Act. It is extrapolated that the visits to the leper colonies would appear unlikely, given the fear of contagion, if indeed such visits were permitted by law. Consequently, it would appear that the lunatics would be the only patients who would suffer from deprivation of family contact in the event of a transfer to an asylum in another province.

b) Girls' and Mentally Defective Women's Protection  
Act No.3 of 1916

The declared aim of this very short law was:

"To consolidate and amend the criminal law in force in the Union relating to the protection of girls under the age of sixteen years and of mentally defective women."

The purpose of this section is to consider whether Act No.38 was promulgated primarily to safeguard the girls and mentally defective women, or whether the main aim was an attempt at eradicating vice from the expanding urban areas. In order to achieve this object it is necessary to clarify the terms of reference in the act and to endeavour to ascertain the proportion of those falling within the ambit of "protection" as specified in this piece of legislation.

Act No.3 of 1916 appears to cover two distinct problem areas:

- a) i.e. child prostitution
- b) "the unlawful carnal connection (except between husband and wife) with any female idiot or imbecile" or "the committing of any immoral or indecent act with such a female".

While the issue of child prostitution does not fall within the parameters of this study, some reference to it was felt necessary at this point.

In historical references it is not always clear whether the under-age prostitutes were children of average intelligence or

whether they were mentally defective. For example Carey (1995) in his biography of William Blake (1757-1827) refers to Lambeth Asylum for Girls. Apparently the aim of this institution was to save girls from becoming child prostitutes, "a species known at the time as chicken whores", according to Carey.

The asylum is only mentioned by Carey because of its close proximity to the Blake home. It is not clear whether the term "asylum" was being used, in this particular instance, to denote a place of refuge, or whether the inmates were regarded as mentally defective. If the latter was the case, then a new issue is raised and one would need to ask if there were a meaningful percentage of mentally defective girls among the child prostitutes in London during the eighteenth and nineteenth centuries. This, however, is beyond the scope of the present study.

Although no direct reference to the prostitution of mentally handicapped children in South Africa could be traced, Vitus (1987) records that in 1913 the Cape Town branch of the Child Life Protection Society met to discuss the problem of vagrancy and prostitution among mentally handicapped young women in 1913. The fact that the problem concerned the Child Life Society would indicate that under-age girls were involved, but this is not stated.

Prostitution, whether under-age or not, is a problem common to all rapidly developing urban areas. It is not clear

from the available records the number of mentally defective women allegedly involved in this trade during the second decade of the twentieth century.

Act No.39 of 1880 was promulgated in the Cape "For the better prevention of certain Contagious Diseases."  
Prostitutes in all the following areas:

The Cape District (including Cape Town);  
The District of Simon's Town;  
The District of Port Elizabeth;  
The District of King Williams's Town;  
The District of East London

were required by law to undergo medical examinations on a regular basis in an attempt to eradicate venereal disease.

The penalties for neglecting or refusing such examinations were severe:

"...she (will) be liable to imprisonment with or without hard labour and with or without spare diet, in the case of the first offence for any term not exceeding one month, and in the case of a second or any subsequent offence for any term not exceeding three months with or without hard labour and with or without spare diet."

One might suggest that if Act No.39 had been rigidly enforced, and all prostitutes compelled to undergo regular



medical examinations, then anyone under-age or mentally defective would have fallen within its ambit and would have been detected.

This act may have resulted in a reduction of prostitution in the Cape, but if so it appears that such success was localised. Prostitution continued, with the women migrating to the more lucrative areas of the Transvaal.

Van Onselen (1982 p.213) states that prostitution in the Transvaal began:

"almost as soon as the first nuggets came out of the Reef in the 1880s - spurred by the proclamation in the Cape of the Contagious Diseases Act, which required all prostitutes to register and undergo compulsory medical examinations."

Van Onselen (1982) adds that prostitutes gravitated to the newly-rich goldfields to escape the Cape law, but that their position was soon challenged by the importation of prostitutes from Russia, America and most of the countries of Europe. Although he asserts that there were over one thousand "ladies of the night" in Johannesburg by the early part of the twentieth century, Van Onselen makes no mention of mentally defective women or under-age girls being among the local prostitutes.

On one hand we have Van Onselen (1982) stating that the prostitutes had left the Cape for the richer pickings in the

goldfields which were established in the late 1880s, and that prostitution in the Transvaal had reached a zenith long before 1913.

On the other hand Vitus (1967) asserts that the Child Life Protection Society did not hold it's first meeting to discuss the problem of vagrancy and prostitution among mentally handicapped young women until 1913.

If these writers are correct, it would appear that both the promulgation of Act No.39 of 1916 and the formation of a society to deal with the problem of prostitution among mentally handicapped young women, did not take place until the meridian of the problem had been passed.

The present writer would suggest that the main concern of the authorities was the eradication of prostitution and vice from the emerging urban areas. Whilst it has not been possible to trace the numbers of mentally defective women engaged in prostitution, the conjecture is that the actual figure would probably be far less than that perceived by society. It will be suggested later in this study that mental deficiency was frequently equated with a lack of morals and that it was this latter condition which was perceived by society to be the greater cause for concern. It is argued by the present writer that the reason legislation correlating the mentally defective with prostitution only emerged in 1916 was that the attention of society had only just become focused on a scapegoat, the newly classified "feeble-minded", who could be blamed for the proliferation of vice.

Act No.38 of 1916 will be more fully discussed in a later section of this chapter, and again in Chapter VIII, but one or two points need to be mentioned at this stage. One of the principal points of focus in Act No.38 is the classification of mental disorders into categories, the highest grade of mental retardation being classed as "feeble-mindedness". It was this category which was to be the target of prejudice and recrimination for the next decade or more, and which will be the subject of Chapter VIII.

Following closely on Act No.38 came a flurry of reports and articles equating the feeble-minded with moral rather than mental deficiency. Dunston (1918 p.12) states:

"...this degenerate class...has a very grave bearing on all our sociological and economic problems, more particularly those of vice, crime and pauperism".

This was, by no means, a new concept. Skultans (1975) and Scull (1989) both assert that in England throughout the first half of the nineteenth century the lack of intellectual ability among the so-called insane was seen by members of the medical profession as equating with a lack of moral judgement.

It would appear that similar views prevailed in the United States early in the twentieth century. Huey (1912 p.2) writing of the feeble-minded states:

"Their presence and conduct subject their families to humiliation; they are an intolerable burden to the teacher and to the schools; they recruit the ranks of criminals, prostitutes, vagrants...(and)...almstakers".

This subject will be discussed in the next section when it will be noted that a category of mental deficiency is classified as "a moral imbecile" in an act of legislation.

It is the opinion of the present writer that while Act No.3 of 1916 implies an intention to afford protection to under-age girls or mentally defective women, the paramount concern was the eradication of crime and the prevention of a regeneration of defective genes.

**c) The Mental Disorders Act No.38 of 1916**

This act was the first major piece of legislation appertaining to lunacy to be promulgated in the immediate post-Union years.

While much of the act was a recapitulation of the provisions for lunatics already covered by earlier legislation, as examined in the previous chapter, there were a number of major inclusions which will be discussed in this section. It should be understood that this piece of legislation applied at national and not provincial level as in the pre-Union acts.

**Clauses 45 and 46**

The incidence of allegedly insane patients residing in private dwellings has already been mentioned in this study. Clauses 45 and 46 of Act no 38 of 1916 introduce certain new dimensions to this form of accommodation:

- a) distinction is made between those residing with "relations or others" who receive no remuneration and those where "payment is received to board and lodge".
- b) a time-limit is imposed on the period a patient may be lodged for payment.

With regard to patients dwelling with relations, a time limit is imposed where "such a defect or disorder has continued for a period of six months and is of such a nature as to require compulsory confinement in the dwelling, or restraint or coercion of any kind". After this six-month period the person in charge of the patient must submit a certificate, signed by at least one medical practitioner, to a magistrate stating the condition of the patient and the reasons (if any) which render it desirable that the patient shall remain in private care.

If satisfied, the magistrate may order that the patient remain in private care for a further period of six months. If there is no improvement in the condition of the patient when the second period has expired, then the necessary steps are to be taken to obtain a reception order.

The purpose of this clause would appear to be to safeguard a patient in need of long-term care from being detained by his family. It provides for the identification and, ultimately, the control of such patients. No mention is made of whether this clause applies to mentally defective children.

Regarding patients being lodged for payment, similar time limits are imposed, initially for six months, followed by one further period of the same duration.

This new piece of legislation would appear to indicate a changing status in the area of private dwellings provided for the allegedly insane. The inference is that these dwellings would become short-term facilities. If this is so, then they would in no way equate with the long-term private madhouses of nineteenth century England, nor with the small-scale privately-funded institutions which have since developed throughout South Africa. No information was available regarding any possible transfer of patients to more permanent institutions at the end of these short-term periods, nor were there any traceable records of the number or size of these private dwellings.

The purpose of Clauses 45 and 46 would appear to be the removal of control over mentally defective or disordered patients from families or privately run institutions and to centralise that control in state mental hospitals.

#### Clause 49

Clause 49 of Act No.38 makes provision for allegedly insane patients to be transferred to general hospitals for medical treatment. This is the first traceable reference to such a facility being made available to patients in asylums. Although earlier records have shown that Somerset Hospital had a wing for general medical patients, there is no evidence of lunatic patients having recourse to this amenity.

The supposition is that prior to Act No.38 of 1916, the Physician-Superintendent at each of the asylums, and other members of his staff, would be qualified medical practitioners and could therefore supply such medical treatment as was thought necessary for the patients. The inclusion of Clause No.49 would appear to suggest that psychiatric medicine was beginning to be seen as a separate, specialised entity from general medicine. Therefore the medical treatment of patients was no longer the province of asylum staff.

It is also an indication that the isolation of alleged lunatic patients was no longer seen as absolute. They were to be admitted to general hospitals, presumably into public wards.

#### Classification of Mentally Disordered or Defective Persons

It is suggested that the prime importance of Act No.38 lay not in any of the clauses it introduced, but in Section 3, of the introduction, where, for the first time in South Africa, an effort was made to implement a sub-categorical definition of mental deficiency and to categorise mental disorder.

#### Class I

"A person suffering from mental disorder, that is to say a person who, owing to some form of mental disorder, is incapable of managing himself or his affairs.

Class II

A person mentally infirm, that is to say, a person who through mental infirmity arising from age or decay of his faculties, is incapable of managing himself or his affairs.

Class III

An idiot, that is to say, a person so deeply defective in mind from birth, or from an early age, as to be unable to guard himself against common physical dangers.

Class IV

An imbecile, that is to say, a person in whose case there exists from birth or from an early age, mental defectiveness not amounting to idiocy and who, although capable of guarding himself against common dangers, is incapable of managing himself or his affairs or, if he is a child, of being taught to do so.

Class V

A feeble-minded person, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility so that he is incapable of competing on equal terms with his normal fellows or of managing himself and his affairs with ordinary prudence and who requires



care, supervision and control for his own protection or for the protection of others or if he is a child, appears by reason of such defectiveness to be permanently incapable of receiving proper benefit from the instruction in ordinary schools.

#### Class VI

A moral imbecile, that is to say, a person who from an early age displays some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect.

#### Class VII

An epileptic, that is to say, a person suffering from epilepsy who is a danger to himself or others or is incapable of managing himself or his affairs."

The contrast between these definitions and those laid down by the American Psychiatric Association (DSM IV) in 1994 (see Chapter I) illustrates the changed perceptions over the past eighty years. Whereby the 1916 Act limits the criteria of achievement, in imprecise terms, to the ability to "manage himself and his own affairs", the 1994 document divides the criteria of "significant functioning" into a series of skill areas, coupled with "significantly subaverage intellectual functioning" observed from a series of applied intelligence tests.

While the 1994 document signifies testing over a wide range of adaptive functioning, no form of testing would appear to have been applied to those regarded as mentally defective in South Africa in 1916. This points to a crucial difference between the two documents. In 1916 "mental deficiency" in every classification was an all-embracing term.

The system of intelligence testing being applied in Europe by 1916 was not yet in use in South Africa. When intelligence testing was commenced in South Africa the scale on which it was used was immense. This will be discussed in a later chapter.

Act No.38 of 1916 made provision for the appointment of a Commissioner of Mental Disorders and from his reports, required annually, the gulf between patients classified as idiot or imbecile and those classed as feeble-minded begins to emerge. It will be noted, however, in the following chapter that the line between the categories of "feeble-minded" and "moral imbecile" are constantly being blurred by Dunston and by other writers.

Dunston (1918 p.12) declared that the lower-grade defectives were no great burden on society, except for the cost of keeping them in institutions, but that the feeble-minded constituted "a most serious menace to social and race advancement". It has already been mentioned that mental deficiency was commonly equated with moral deficiency. In South Africa moral deficiency among Europeans was regarded as undermining the supremacy of the white race, as illustrated by Dunston's final phrase. It will be shown in the following

chapter that the retention of racial supremacy appeared to outweigh all other concerns during the 1920s/30s and that the Depression which followed World War I was to have a great impact on the perception of feeble-mindedness in South Africa.

In his report for 1918 Dunston estimates that there were approximately 3,000 feeble-minded adults in the Union, with an additional estimate of 3,000 feeble-minded children attending school at that time. No figures were given for those children not attending school.

As feeble-mindedness in other races was not acknowledged at that time these figures would appertain only to whites. The general population census for 1918 stated that the figure for whites was 1,421,781, giving the percentage of feeble-minded, school-going or adult, as 0.422%.

Prior to the recognition of feeble-mindedness as a category of mental deficiency this group of persons appeared to have presented little or no problem. Having once been recognised, however, they were perceived to be a menace to society and to the preservation of white supremacy in South Africa. Coupled with this, was the economic situation in 1918. Having emerged from World War I, South Africa, in common with much of the western world was about to enter an economic depression. It is on these issues that the following chapter will focus.

The legislation covered by Act No.38 was to remain in force until 1973, with the addition of a few amendments. The control over the detention of the mentally disordered or the

mentally defective rested with the State, but required the provision of two medical certificates before a patient was legally committed. Patients were, theoretically provided with reasonable safeguards against neglect or abuse; they had recourse to general hospitals if necessary and to the right to appeal against wrongful detention.

The classification of patients had far-reaching implications for those in the feeble-minded category and these will be discussed in Chapter VIII.

## Chapter VIII

### Feeble-mindedness;

#### The Alleged Correlation Between This and Poor Whiteism

Chapter VII discussed legislation apertaining to lunacy in the immediate post-Union years. Of particular relevance to the present chapter was Act No.38 of 1916 which was the first attempt in South Africa to classify mental defectives into seven categories. It was noted that the highest grade of mental deficiency was classified as feeble-mindedness. This category was to be the focus of attention for mental health authorities for the next two decades and will, for this reason, form the nucleus of Chapter VIII.

The sources used in this chapter cover the period from 1918, the date of the first report of the Commissioner in Mental Disorders, to 1934, when the report of the Carnegie Commission of Investigation on the Poor White Question in South Africa was published. Although originally scheduled as annual accounts, the reports of the Commissioner in Mental Disorders (later known as the Commissioner for Mental Hygiene) were actually issued at approximately two-yearly intervals until the early 1930s and will be referred to where appropriate.

The recommendation to appoint a Commissioner in Mental Disorders appeared in Act No.38 of 1916. The first appointee was Dr.J.T.Dunston, who submitted his initial report in 1918. Dunston gave pressure of work as the reason for the lengthy delay in the first submission.

This first report left no doubt about Dunston's attitude towards the feeble-minded:

"The seriousness of the problem had not been realised in any country until quite recent years....Very extensive researches in America and Europe now being undertaken show without doubt that the presence and multiplication of this degenerate class constitute a most serious menace to social and race advancement, and the subject is receiving in other countries the serious attention it deserves."

Report of the Commissioner in Mental Disorders (1918 p.12)

The "very extensive researches in America and Europe" mentioned by Dunston included the implementation of intelligence tests devised by Binet and Simon. These tests were becoming widely used on school children in Europe during the early twentieth century. America used a similar form of testing and put it to a new purpose. Based on Binet's tests, but adapted by Terman under the title of Alpha, and later, Beta Tests, these were used during the 1914-1918 war, for testing recruits who could not speak English.

There is little doubt that the introduction of compulsory elementary schooling in England in 1870, which brought the problem of "backward" children to the attention of the education authorities, exacerbated the perceived need for intelligence testing. It may also be suggested that compulsory conscription into the army in 1914-18 revealed a high level of "backwardness" among recruits and brought the problem of feeble-mindedness to the fore in Europe and in America.

It would appear that intelligence testing in South Africa began towards the end of the second decade of the twentieth century, and this subject will be discussed in a later chapter.

It will be shown that the perceived problem in South Africa lay, not only in the identification of the feeble-minded, but in the racial implications of such a discovery. It is the attitude of the government and the medical profession towards the feeble-minded that is of particular pertinence to this chapter.

Throughout his tenure as Commissioner in Mental Disorders, Dunston strenuously asserted the need to apply rigorous methods of control over the feeble-minded, even more stringent than those imposed on the lower grade defectives. These views, together with those of other writers, are particularly germane to this study.

Feeble-mindedness, identified as the highest category of mental deficiency in the 1916 act, was later to be defined in the Van Schalkwyk report of 1928-30 as an I.Q. level of 45-60, with a border zone to 75. Burt (1957 p.12) states that in England in 1899 the Royal College of Physicians defined and recognised a new group of mental defectives, namely:

"Those who, not being imbecile, and not being merely dull or backward, are, by reason of mental defect, incapable of receiving proper benefit from the

instruction in the ordinary public elementary schools, but are not incapable by reason of such defect of receiving benefit in such special classes or schools ..."

Although not termed "feeble-minded" this is clearly the category defined.

In South Africa feeble-mindedness became seen as the associated adjunct of poor whiteism and as such continued to be the central focus of mental health authorities throughout the period of the post-World War I Depression.

The problem of poor whiteism in South Africa was considered to have reached significant proportions during the second decade of the twentieth century and was to continue to escalate throughout the following two decades. It will be shown later that this phenomena could not be attributed to one particular cause, an accumulation of natural and man-made disasters all contrived to exacerbate the situation.

The level of intellectual ability then described as feeble-mindedness has always been present in any society, so one must pose the question of why these persons suddenly become the focus of attention, not only for the medical profession but also at government level.

It has already been suggested that compulsory education and conscription to the army were likely to have been contributory



factors in the identification of feeble-mindedness in England and in America. It is further suggested that in South Africa the social and economic conditions prevailing during the immediate post-World War I period played a decisive role in the handling of this problem. This chapter will examine the reasons for this suggestion; the problems of feeble-mindedness peculiar to South Africa, and the solutions proffered by the mental health authorities over a span of some twenty years.

It will have been noted that no mention of race was made in any of the Acts discussed in previous chapters. It would be erroneous to presume this omission signified that all races were perceived to be on an equal footing. Earlier chapters of this work indicated racial segregation in each of South Africa's asylums, with blacks either being employed as a work force in institutions for European patients, or relegated to inferior institutions reserved for their own racial group.

The major piece of post-Union legislation, namely Act No.38 of 1916, contained no changes in this respect. The lower grade black defectives were to remain in the institutions, but while so much attention was being focused on feeble-mindedness among the whites, such a condition among other race groups was ignored.

The extract quoted below illustrates the perception, then extant, that feeble-mindedness was, almost solely, the prerogative of Europeans. It will be seen that this view still prevailed some twelve years after the initial identification of feeble-mindedness.

"No special institutions for the feeble-minded have been established for other than European races, as so limited a number of these has been notified or certified that there was no justification for establishing such institutions. It has, however, been made evident - as a result of surveys... that the need exists for institutions... particularly for the coloured. The need hardly exists in regard to the aborigines because - it would appear - of the results of the instinctive eugenic practices and customs amongst native tribes from olden times. ...With regard to the Asiatics, we know little or nothing. ...It would appear that among the Asiatics either the problem is a very small one or they deal with it as a community."

Report of the Commissioner for Mental Hygiene

(1928/29 p.vii)

Although the racial issue is to be discussed in a subsequent chapter the deliberate refusal to recognise feeble-mindedness among race groups other European requires some comment at this point.

Fick (1929 p.703), having conducted the Army Beta I.Q. tests (previously mentioned) on groups of native (Zulu) children, states,

"...these medians were so low that they almost tally to a marked degree with those found in the case of educable defectives."

Fick was expressing a belief which was, according to Davies (1979) commonly held during the period; that the feeble-minded of European extraction were still mentally superior to the ordinary black. In order to maintain such a theory any notion of feeble-mindedness among blacks had to be ignored. To acknowledge such a category would, by inference, concede that the vast majority of blacks were of normal intelligence, on a par with their white counterparts.

Because of governmental attitude to the problem of feeble-mindedness among other races, this chapter will centre on the perceptions of, and the recommendations for, the feeble-minded within the European race group, focusing on the social and economic problems peculiar to South Africa and on the outcome of these issues.

#### Provisions for the Feeble-minded Prior to their Identification

If, as Dunston (1918) suggests, the feeble-minded in England were regarded as a serious menace early in the twentieth century, perhaps one should question where these people were before their condition was defined. They may have remained unidentified in the custody of their families, but given the large scale migration from rural areas to newly developing industrial centres during the mid-nineteenth century, as discussed in Chapter III, this would appear unlikely.

One proposed explanation would be that they were included in the numbers of lunatics detained within the vast new

asylums, mentioned in Chapter III. Scull (1989) and Rothman (1971) assert that the inmates of these asylums were predominantly pauper lunatics and this chapter will show that in South Africa feeble-mindedness, in the earlier part of the twentieth century, was equated overwhelmingly with low-income families. It is therefore suggested that it was the feeble-minded who contributed significantly to the numbers who filled the new asylums in nineteenth century England and that they were the ones released when the astronomical costs forced a drastic reduction in patients towards the end of that century.

If this theory is correct it would account for the concern of the English authorities, mentioned by Dunston (1924-25), over the numbers of allegedly feeble-minded persons within English urban communities during the first two decades of the twentieth century. If, as Scull (1989) states, large numbers of patients were discharged from the asylums around the end of the nineteenth century it would be reasonable to suggest a correlation between the two events.

In South Africa the asylums, constructed towards the end of the nineteenth century, were never intended to accommodate large numbers of patients. It is suggested that those later to be identified as feeble-minded were cared for by their families or communities.

By the early years of the twentieth century the poor whites were beginning gravitate to the newly established urban areas in search of work. This migration escalated during the depression which followed in the aftermath of World War I.

Dunston (1918) alleges that the incidence of feeble-mindedness among the poor whites was disproportionately high compared with the more affluent Europeans. If this was the case, it would appear likely that the concern in medical and governmental circles arose from the so-called feeble-minded being brought into the towns by their families in considerable numbers.

Because South Africa had never attempted to emulate the size of the asylums built in Britain during the first half of the nineteenth century space in South African institutions was always at a premium. It is suggested that prior to the 1916 Act the vast majority of the feeble-minded in South Africa remained unidentified and in the custody of families or friends. What was to bring this category into central focus was not a sudden upswing in humanitarian concern for the feeble-minded, but a socio-economic crisis of phenomenal proportions.

#### The Poor White Problem in South Africa

A detailed study of poor whiteism is beyond the scope of this work, but because of the implied correlation between this problem and the feeble-minded it was considered expedient to present a brief summary of the factors which lead to the poor white phenomena.

Davenport (1987) states that as early as the 1860s a cycle of poverty began in the Cape with a series of disastrous economic slumps which were to continue throughout the 1870s/80s and led to many small farmers losing their land.

Poverty was further exacerbated by the devastating outbreak of rinderpest in 1896/7 and by the burning of Boer farms by the British during the South African war.

The Report of the National Commission on the Poor White Problem (1930) and the Report of the Carnegie Commission (1934) divide those likely to fall into the category of poor whites as follows:

- a) nomadic types, i.e. poor "trek" farmers of the North West Cape
- b) a poor class, i.e. bywoners, farm labourers and shepherds (as in the Karoo)
- c) bushveld type, living under pioneering conditions in the Transvaal
- d) poor type of woodcutter - Knysna, George, Tsitsikama region
- e) small groups of indigents - group isolated - along rivers/valleys
- f) former independent farmers now in poverty due to drought, disaster, mismanagement or divided farm system, i.e. division of farm among sons, eventually resulting in areas of uneconomic proportions.

The Reports compute the likely migration pattern of these groups as follows:

- a) moved to small towns and became "village paupers"
- b) moved to large cities worked as manual labourers
- c) tried their luck at the alluvial diggings
- d) survived on temporary Government-created relief work.

The above reports represent families or small communities living on or below subsistence level. They have failed to thrive in rural areas because of mismanagement, natural disasters, slumps in the economy, or a combination of all three factors. Unable to support themselves in the rural areas they migrate to the towns in search of employment.

Davies (1979) states that official statistics place the number of poor whites in South Africa as high as 100,000 in 1919, with this figure escalating to 300,000 as the Depression worsened. Unskilled and poorly educated, the poor whites were seeking employment in a labour market where unemployment figures were reaching unprecedented heights.

The Report of the Carnegie Commission (1934) defines a poor white as:

"A person who had become dependent to such an extent, whether from mental, moral, economic or physical causes, that he is unfit, without help from others, to find proper means of livelihood for himself or to procure it directly or indirectly for his children."

The likelihood of anyone who has declined to this extent finding employment when skilled or professional men were unemployed was minimal. Thus the poor whites became the urban unemployed and were forced to rely on begging or whatever charity or doles that were available. The best they could hope for was the occasional odd job. Davies (1979)

According to Touleier (undated) and Gundefinger (1930) the position in South Africa was unique in that labouring work was regarded as "Kaffir work" and beneath the dignity of the whites. They assert that even poor whites with starving families would not accept offers of manual labour. Davies (1979) disputes this, contending that the mine owners in particular employed black labour over white because it was infinitely cheaper. A white, even a poor white, had to be paid a wage on which a family could at least subsist, whereas a black labourer was parted from his family, housed and fed, at minimal cost, on the mining compound. The present writer would suggest that if the poor whites were reduced to living among the blacks and coloureds, often below subsistence level, as Touleier and Gundefinger affirm, then it is likely that any artificially created barrier of racially defined occupations would cease to have relevance for them.



The definition of a poor white as interpreted by the Carnegie Commission has already been quoted. Touleier, in an undated pamphlet, delineates another definition which contains a significant addition:

"(A poor white) is one whose means will not enable him (or her) to maintain in any particular community a standard of living commensurate with the standards of ordinary decency and morality ... (and who) must inevitably sink ... until it becomes difficult to differentiate it from the standards of the native."

It will be noted that Touleier places emphasis is two areas, namely the maintenance of a standard "within any particular community" and on "decency and morality". This statement is indicative of prominence placed on these issues by numerous writers, Gundefinger (1930) and Dunston (1926/7) among them, during the Depression. It was not the welfare of the poor whites that was the main concern of white society, it was the fact that the poor whites had fallen below the standards normally accepted by their "particular community". They were now forced by circumstances to live on the level of non-Europeans and had consequently put themselves "beyond the pale".

One would have hoped a humanitarian society would have focused on the demoralising effect of unremitting poverty on the poor whites. Instead it would appear that attention centred on their alleged lack of moral values. One assumes

that, rightly or wrongly, the moral values of non-European groups were regarded as unacceptably low to white society.

The very term "poor white" signifies someone unable to maintain a standard of living considered appropriate for the white community. In a South African context this was the crux of the problem. A poor white may have been no worse off financially than an unemployed coloured or black, but such comparison was never made. To the white South African community the importance lay in the fact that someone of European extraction had crossed what Dunston (1926/27) referred to as "the unbridgeable gulf" between the races and was living at a level considered unacceptable to the white community.

Dunston (1926/27 p.vii) writing on the subject of poor whites, asserts that:

"... The tendency of one socially and spiritually bankrupt to gravitate towards inferior racial levels, i.e. coloured and natives, is a feature that has often been observed. Now the South African born rightly regards himself as separated from the coloured and natives by an unbridgeable gulf created in the history of our country and our people. When, therefore, we find some of our poor mixing intimately with these inferior ethnic types, we may justifiably conclude that they by doing so sacrifice the heritage of race..."

The extract from Touleier (undated) quoted earlier in this section, illustrates the fact that Dunston was not alone in his opinion of poor whites. Gundefinger (1930) writes in similar vein of poor whites living alongside blacks and coloureds, in some cases citing instances of co-habitation between the races. Furthermore, it would appear that Gundefinger (1930) equates all the progeny of poor whites with feeble-mindedness, because he advocates that they should be removed from their homes and placed in hostels.

Underlying each description quoted above is the inference that indifference and apathy contribute to the deplorable condition in which the poor whites find themselves, and that as members of the white race they should have had the moral strength of character to overcome their difficulties.

As the novelists quoted in Chapter II reflected views of nineteenth century society on lunacy, it was hoped that some fictional account of poor whites living among other race groups during the Depression could be traced. Unfortunately no such literature could be located, although assistance was given by both the Department of English at the University of Natal, Pietermaritzburg, and the Natal Society Library, also in Pietermaritzburg. Perhaps one might assume that the lack of such literature reflects the fact that this was a subject white society chose to ignore rather than publicize, even in fictional form.

One of the interesting comparisons to emerge from this section of the present study is the marked similarity between

the attitude of society towards poor whites and towards the mentally defective women discussed in the previous chapter. The poor whites were consistently associated with vice and crime of every description. The mentally defective women were accused of being involved in prostitution.

It would appear that because neither group adhered to the parameters of white society, they are being classed as morally defective. Their actual "crimes" may have been penury or sub-average intelligence, but Dunston (1918-28), Gundefinger (1930) and Touleier (undated) are among the many writers who regard both groups as morally corrupt. It is suggested that failure to conform to social norms was, in itself, seen as a major crime.

On the other hand, Davies, (1979) asserts that the major crime among the poor whites was distilling and selling illegal liquor to the natives and coloureds. This assertion was substantiated by the findings of the Carnegie Commission. It appears likely that such trade would serve to strengthen the association between the poor whites and the non-Europeans, and distance them further from the more affluent whites within the community.

#### The Purported Correlation Between Poor Whites and Feeble-mindedness

According to Dunston (1918), Gundefinger (1930) and Touleier (undated), the dilemma of poor whiteism was

exacerbated by the high incidence of feeble-mindedness among the poor whites.

Dunston (1918) estimates there were 3,000 individuals known to be feeble-minded at the time of his report. However the basis for this estimate remains unclear. Earlier in the same report Dunston refers to the Report of the Royal Commission in Great Britain on Mental Defectiveness published in 1908, but gives no details of the contents therein. Later, Dunston states,

"It is difficult to estimate the number of adult feeble-minded in the Union. If we take the figures of the Royal Commission as a guide the number would be about 3,000."

Report of the Commissioner in Mental Disorders,  
(1918 p.16)

One can only assume that the British Royal Commission report contained a suggested ratio of mental defectives per normal persons in the population and that this was the calculation Dunston was using for his own estimate.

Both Dunston (1918) and Gundefinger (1930) assert that feeble-mindedness, with very few exceptions, occurred only in the poor white community. Dunston states:

"The psychological side of the poor white problem demands quite as much attention and investigation as any other....The primary cause of poverty is, I am

convinced, the inherent incapacity as a result of feeble-mindedness to compete on equal terms with normal individuals. Men are not born equal. There can be no equality of opportunity in the struggle for existence between the normal individual and the feeble-minded. Feeble-mindedness may not be the only cause of poverty but it is safe to say that not one of the problems of poverty can be solved until all the feeble-minded have been weeded out of this group under consideration, and suitably dealt with apart from the normal remainder."

Report of the Commissioner in Mental Disorders,  
(1918 p.14)

Even if their assumption were correct, and one accepts the figures given by Dunston and Davies, i.e. poor white population 100,000; known number of feeble-minded 3,000, the ratio of feeble-mindedness within the poor white population would not appear to be abnormally high, yet Dunston and Gundefinger depict it as an overwhelming problem.

Dunston (1918) sees the correlation between poverty and feeble-mindedness as a self-perpetuating condition producing a vicious circle. As his statement quoted above illustrates, Dunston maintains that the primary cause of poverty is a result of the inherent incapacity of the feeble-minded to compete on equal terms with normal individuals. Having failed in his unequal struggle, the feeble-minded individual then sinks lower into poverty, regenerating his condition, physical and mental, among his off-spring.

It will be mentioned later in this chapter that during the 1920s Dunston embarked on a lengthy tour of mental institutions in the United States where the theory and practice of eugenics was currently in vogue. Taking into account Dunston's frequently expressed views on the economic and social repercussions of the regeneration of feeble-mindedness one is somewhat surprised that he failed to advocate such a practice in South Africa.

In contrast to the writers mentioned earlier, the Carnegie Commission report (1934) argues that the great majority of poor whites were of normal intelligence:

"An extensive intelligence survey shows that the great majority of poor whites are of normal intelligence. The poor white's intelligence is lower on the average than that of the European population as a whole, and the percentage of them classed as subnormal is approximately twice as large as that of the European population as a whole. But about one-third of them have more than average intelligence, and some are even exceptionally gifted. In addition the development of the intelligence of the poor white child clearly suffers from unfavourable environment. Hence their potential intelligence is higher than would appear at first sight from the results of intelligence tests. The survey shows very clearly that the greater proportion of them constitutes a source of human material which need not be a burden, but which may, granted a sound state policy, become a very decided asset to the Union."

Joint Findings and Recommendations of the Carnegie  
Commission (1934 Section 85)

The Carnegie Commission (1934) also reported that to a considerable extent the degree of retardation ran parallel with the degree of poverty. If this was the case then it is suggested that the levels of retardation among the most destitute of the poor whites would be well below the category of feeble-mindedness. It is interesting to note that Dunston, in 1918, failed to make a similar deduction. One would feel that such a claim would have strengthened his argument about the degeneracy of the poor whites.

In none of his reports over a twelve year period did Dunston ever reach a similar conclusion to the Carnegie Commission when they reported that about one third of the poor white population was above average intelligence and that some were, against all the odds, exceptionally intelligent.

Poverty in itself does not cause mental retardation, but an amalgam of genetic and environmental variables including malnutrition, inadequate housing, poor physical health of mother and child, and the absence of intellectual stimulation, are all contributory factors to cultural/familial retardation. On these matters there is general concensus in the literature on mental retardation. It is suggested that the most common mental defects among the poor whites were scholastic backwardness or cultural/familial retardation on a large scale.



Dunston (1918) and Gundefinger (1930) frequently refer to the poor whites and the feeble-minded as one amorphous group, implying a generalised low level of intelligence, although, as already stated, the Carnegie Commission found that the majority of poor whites were of average intelligence.

In reality what we are actually seeing is two distinct groups:

- a) the poor whites who have migrated from rural areas. Inadequately educated, unskilled and ill-equipped to cope with life in an urban environment, but of normal intelligence.
- b) those among the poor whites who were feeble-minded, possibly suffering from cultural/familial retardation, in all probability having little or no education and considered unemployable.

The Report of the Carnegie Commission (1934) blamed the inability of the poor whites to function effectively on an inadequate system of education. The method of teaching in rural schools focused mainly on religious instruction and was suited only to the simple needs of those in relatively isolated rural areas. To keep pace with any new developments in education was deemed unnecessary, indeed this was regarded as "something English" and therefore alien to the Boer culture.

This would suggest that the basic problem for the poor whites in general was inadequate education rather than mental retardation, and that this situation, exacerbated by poverty, was responsible for the allegedly high proportion of feeble-minded children.

Desperate for a solution to the poor white problem the government began, in the mid 1920s, to institute a system of relief work for the unemployed poor whites. Although the term "relief work" is not clearly defined by Davenport, (1987) it would appear to have been in the form of short-term employment offering only temporary relief to the participants.

In an effort to provide work of a more permanent nature for the unemployed poor whites it appears that the government took two steps.

The first was to instigate an intensive system of extending, servicing and maintaining the country's road and rail system. Thus the relatively uneducated and unskilled poor whites were provided with employment falling within the range of their capabilities. According to Davenport (1987) between 1924 and 1933 the percentage of unskilled white workers on the railways rose from 9.5% to 39.3%.

The second step was the introduction of the "civilised labour scheme" which banned blacks from holding all but the most menial of posts. This meant that whites took over the unskilled or semi-skilled posts formerly held by blacks. The fact that this method of job reservation reduced countless

blacks to penury far worse than that of the poor whites was largely ignored.

It is ironical to note that in the Depression years the job reservation scheme for whites included, according to Davis (1979), such employment as chauffeuring official government cars and acting as door-keeper in government offices, jobs which in later, more prosperous times, were to be considered too demeaning for whites, and only suitable for non-Europeans.

The advantages to white society of the "civilised labour scheme" might be viewed as two-fold. By providing the poor whites with employment there was hope that they might improve their social status and take their "rightful place", a phrase frequently used by Dunston, in the "superior race" once more.

In addition, because the scheme was principally involved in the maintenance and servicing of railways and roads, the poor whites were removed from the vicinity of urban townships and their contact with natives and coloureds. In effect the process might be regarded as cyclical; driven from the rural areas by financial failure, the poor whites had migrated to the towns only to be confronted by even greater decline. Now bolstered by government funding they were translocated once more to rural areas.

It is also suggested that, if, as Dunston (1918 and 1926/27) maintains, the poor whites were the sole progenitors of the feeble-minded, then the relocation of families to

isolated areas would remove a considerable number of their feeble-minded progeny from the cities. Such an action was not, of course, a solution, but it is suggested that in the short term, such a scheme would remove the feeble-minded from the temptations of the city, to which they were perceived to have considerable proclivity.

It was not, of course, the answer to the problem of the regeneration of feeble-minded progeny, but it is suggested that it was easier for society to ignore such children if they were on some distant location.

It will have been noted that the definition of feeble-mindedness in Act 38 of 1916 rested on social or behavioural factors, with no reference being made to the assessing of intelligence testing.

By the second decade of the twentieth century intelligence testing was at the forefront of thinking in the field of mental health in Europe and America. The advent of I.Q. testing in South Africa afforded Dunston and his colleagues, Moll, Crosthwaite, and later, Fick, the opportunity to verify their theory that an inordinantly high proportion of delinquents were feeble-minded. Dunston (1918) writes of "intensive investigations", but unfortunately the published results are sparse and the methods of testing remain unspecified.

The results quoted by Dunston (1918) are given below:

Breakwater Reform School - out of a total of 40 boys  
25% (10 boys) were mentally defective, if borderline  
cases were included the total rises to 35%

Estcourt Reform School - out of a total of 19 boys 10.5% (2 boys) were mentally defective, if borderline cases are included the total rises to 26.3%

Pretoria Rescue Home for Girls - total number unspecified, 25% stated to be mentally defective, higher (unspecified) if borderline cases included.

It has not been possible to establish the total number of such institutions in South Africa during the second decade of the twentieth century. Dunston (1918) refers to tests being administered in other institutions, but provides neither location nor statistics. It is suggested that the limited results supplied were too insubstantial to prove conclusive.

Between 1918 and 1926/7 Dunston's reports contain frequent reference to the propensity of the feeble-minded towards crime and "moral delinquency". In his report for 1926/7 p.vii he states:

" A mental survey of the Juvenile Adult Reformatory was made by Dr. Gillis. His findings confirm results obtained there on the occasion of a previous examination. Thus he found 6 per cent. so manifestly mentally abnormal that these were certified and committed under the Mental Disorders Act. A further 15 per cent. he found to be borderline cases requiring custodial care and treatment of a special kind. A further number representing 29 per cent. of inmates are described as "mentally inferior."

This statement would appear to infer that exactly half of the inmates of the reformatory were mentally retarded to varying degrees.

From his first report in 1918 Dunston constantly emphasises the need for special institutions for the feeble-minded where they could be housed well away from the delinquents in the reformatories and also from the lower-grade defectives in the mental hospitals. Unfortunately governmental response to Dunston's requests was slow.

d) Institutions for the Feeble-minded in South Africa 1920s

By 1921 the only state-funded institution for the care of the feeble-minded was the Alexandra Institute in Cape Town.

In 1922, under the auspices of the Cape Town Society for the Care of the Mentally Defective, an institution known today as Adam's Farm was opened for "the care of young feeble-minded women". Vitus, (1987).

The following year the Witrand Institution for the Feeble-minded at Potchefstroom, in the Transvaal, was opened for "the special care and training of mental defectives". Report of the Commissioner for Mental Hygiene (1930/31/32.1)

It is interesting to note that in spite of the policy frequently advocated by Dunston, (1918-1924/5) neither of the state-funded institutions appears to have been single-sexed.

The only available statistics for Alexandra and Witrand for the period under review raise certain questions.

Direct Admissions to Institutions for the Feeble-minded:

|        | <u>Rate per 1,000 of Population</u> |      |      |
|--------|-------------------------------------|------|------|
|        | 1930                                | 1931 | 1932 |
| Male   | 1.40                                | .79  | .76  |
| Female | 1.16                                | .40  | .59  |

Discharges - Calculated as Percentage of Direct Admissions:

|        | 1930  | 1931  | 1932  |
|--------|-------|-------|-------|
| Male   | 32.55 | 54.05 | 43.05 |
| Female | 22.33 | 30.55 | 24.07 |

Report of the Commissioner for Mental  
Hygiene 1930, 1931 and 1932.

Regarding admissions, it will be noted that these percentages are remarkably low, even taking into account the fact that they refer only to members of the European population.

The Report offers no explanation for the number of discharges, which appear to be phenomenally high when one considers that mental retardation is not normally regarded as a treatable condition. It is possible that:

- a) wrongful diagnosis initially, possibly through the application of intelligence tests as mentioned below

- b) many of those discharged were "borderline cases" referred to in the statistics on intelligence testing, and that the cost of institutionalising them raised expenditure to unacceptable heights.

One can only conjecture whether those discharged were returned to their families or were dispatched to mental hospitals.

#### Early Intelligence Testing in South Africa

Vitus (1987 p.32) records that by the early 1920s the mental health societies were joining the government agencies in pressing for the extensive use of intelligence testing on children. He reports that in 1922 the society in Johannesburg:

"...escorted 82 persons to their (Drs.Moll & Leipoldt) consulting rooms, where they were tested and certified to mental hospitals."

Vitus, (1987) gives no background information on this group, but the present writer would suggest that to have all of the eighty-two children "certified to mental hospitals" indicates an approach which is too arbitrary. While one can perhaps accept that the children in this group were selected for testing because their mental defects appeared obvious to teachers who had been in contact with them, such a comprehensive conclusion raises doubts as to the validity of



the tests. One would have expected at least a small minority to have tested as feeble-minded, and therefore not be subject to certification in a mental hospital. It is suggested that such testing may have contributed to the high number of discharged patients shown above.

According to Minde (1975) the Binet Simon; Terman, and "other tests" were used extensively in South Africa during the first quarter of this century, and he reports that these were found to be unsuitable.

The Carnegie Commission (1934) found the poor whites to be almost exclusively Dutch-speaking, and according to Minde, (1975) the intelligence tests were administered by English practitioners, newly arrived in South Africa and unfamiliar with the Afrikaans language. This would lead one to suppose that the tests used were non-linguistic in responses and directions. Even so, it is suggested that the children from socially deprived backgrounds may have been greatly disadvantaged by their unfamiliarity with the manipulation of symbols and the handling of coins. A similar argument will be used later in this work, when the use of intelligence tests among non-European children is discussed.

Minde, (1975) states that the Official Mental Hygiene Scale for South Africa was standardised in 1927, when Fick adapted the questions based on Terman's Stanford Revision and Burt's Individual Scales to suit local conditions.

It is therefore suggested that prior to 1927 the classification of the feeble-minded was determined either without the benefit of I.Q. testing, or by the administration of tests that were flawed and discriminatory. When one reviews the preconception revealed in the derogatory wording of official documents during the 1920s-early 1930s it is possible that malevolence against the feeble-minded caused bias during testing and contributed further to prejudicial results. Later in this study reference will be made to the methods of I.Q. testing non-European children and here again results suggest a jaundiced approach.

It is theorised that South Africans of European extraction, fortunate enough to have escaped the ravages of the Depression, were so incensed and mortified by the poor whites' abandonment of the accepted standards of the white community that their prejudice outweighed measured judgement. The fact that the poor whites were left with little choice other than seeking refuge among the "inferior" races appears to have been ignored. It is suggested that this prejudice led to both the poor whites and the feeble-minded being used as scapegoats for the vice and crime which is inevitable in urban environments at times of high unemployment.

f) Solutions Proposed for the Problem of Feeble-mindedness  
in South Africa Between 1918 and the 1930s.

Dunston (1918) and Gundefinger (1930) assert that urgent solutions were needed in order to deal with the two major problems associated with feeble-mindedness:

- a) the regeneration of feeble-mindedness through breeding
- b) the proclivity of the feeble-minded towards vice and crime.

It has been stated earlier that Gundefinger (1930) advocated removing the children from all the poor white families and placing them in sexually segregated hostels in order to prevent the regeneration of feeble-mindedness. It is not clear whether Gundefinger (1930) was suggesting these persons should remain in custody for life, but given the reason for their committal, one must assume that this would be for their entire productive cycle.

In his Report of 1918 Dunston had advocated a similar course, stating that it is imperative the State assume control of the feeble-minded. He argues (1918 p.17) that:

"the present law does not give the necessary powers to the Government to do this. At present they can only be dealt with...(when) not under proper care, treatment and control, or neglected or cruelly treated, a danger to themselves or others, or when criminal, indecent or inebriate, or in the case of a woman, pregnant of or giving birth to an illegitimate child when in receipt of relief from public or charitable funds."

Dunston's recommendation (1918) was that all the feeble-minded "not under proper guardianship" be placed in segregated farming and industrial colonies in order "to prevent the

transmission of the feeble-minded strain in ever increasing generations." The phrase "proper guardianship" in Dunston's terms contains a certain amount of ambiguity. In his previous paragraph he is seeking an amendment to the law in order that all the feeble-minded might be brought under State control, regardless of the standard of their supervision. The assumption would appear to be that "proper guardianship" would imply those feeble-minded already institutionalised. No traceable evidence has been found to substantiate the founding of such colonies.

In his 1918 report Dunston concludes his recommendations with the assertion that if his recommended measures were efficiently enforced the feeble-minded population would largely disappear in two or three generations.

However, in his report of 1924/5, some six years later, Dunston asserts that "so far it has been the policy of the department only to send the child to an institution if conditions are so bad that the child has been either grossly neglected or out of control or in moral or social danger" Report of the Commissioner of Mental Hygiene (1924/5 p.x)

From the available evidence it is apparent that enforced sterilisation was never envisaged as a practical solution to controlling the feeble-minded in South Africa during the 1920s/1930s. The van Schalkwyk Committee 1928-1930 recommended that "voluntary or by consent sterilisation of the mentally defective under certain conditions" should be made legal and that in certain cases should be permitted as a condition of release from institutions. This recommendation

was only to come into effect in 1975 with the passing of the Abortion and Sterilisation Act No.2 of 1975.

In 1972 the Commission of Inquiry into the Mental Disorders Act No.38 of 1916 was formed. It was their report, known as the J.T.van Wyk report, which included the following recommendation:

"...that where the sterilisation of a patient is necessary in the interests of the patient's mental health or the well-being of the patient's children or there is a substantial risk that the future of children of such a patient might be seriously handicapped by physical or mental abnormalities, such sterilisation should be authorised."

The J.T. van Wyk report (1972 p.61)

Although the report proposed that a new chapter on "sterilisation and termination of pregnancies" should be added to the proposed 1973 Mental Health Act, this was not done. This suggested chapter was later to appear as a separate piece of legislation; the Abortion and Sterilisation Act No.2 of 1975 mentioned above. However, Vitus (1987) asserts that voluntary or by consent sterilisation (sic) had previously taken place under common law.

The only record of support for enforced official sterilisation of the mentally defective in South Africa was contained in a letter written by the Chairman of the Cape Province Society for Mental Hygiene to the National Council of Mental Health Societies in 1934:

"I wish our Commissioner was not so terribly opposed to sterilization of the mental defectives. I wish we could have Herr Hitler in command here for 6 months to deal with the mentally unfit. I highly approve of legislation in that respect."

Cited in Vitus (1987 116)

In 1934 Hitler's solution to the problem of mental deficiency was sterilisation. His "ultimate solution" of liquidation was to follow later.

g) The Eugenics Movement in the United States in the 1920s - 1930s.

At the onset of the present research it was envisaged that the section on feeble-mindedness among the poor whites would be concentrated solely on the situation in South Africa. However, parallel incidences were traced in the United States where feeble-mindedness was also associated with poverty and those judged socially inadequate. As in South Africa, the issue was one of perceived moral defectiveness, rather than mental deficiency.

Because the situation in America paralleled that in South Africa, with the allegedly feeble-minded being regarded as morally delinquent, it was felt that to refer to South Africa in isolation would be to present the issue out of context. It is for this reason that an account of the sterilisation policy in the American state of Virginia is included in Appendix III.

There is a tendency to associate the mass sterilisation of mental defectives exclusively with Nazi Germany, but Paul Lombardo, an historian at the University of Virginia asserts that the Germans adopted their policy of eugenics, technically "the science of good breeding", after witnessing the practice in America, where the movement found much support in the 1920/30s. Lombardo (1995)

Supporters of the eugenics movement advocated the survival of the fittest, believing that good breeding should be encouraged and that those physically or mentally unfit should not be allowed to reproduce. According to Lombardo (1995) an issue which gained the eugenicists much support was not only their plea for racial purity, but their stress on the enormous financial savings envisaged if the nation was relieved of the cost of maintaining the unfit on welfare programmes.

In England a number of prominent figures, including H.G.Wells, Bernard Shaw and Winston Churchill, advocated the implementation of a eugenics policy, but support was purely for the broad notions expressed. Such ideas were never put into policy or practice. Crockett (1995)

Dunston visited the United States on an extensive tour of mental institutions during 1921/2. Referring to this visit in his 1924/25 report Dunston makes no mention of the policy of eugenics nor of sterilisation. Given Dunston's pre-occupation with the feeble-minded during that period, the present writer sought to trace records of any contact he may have made with the Lynchburg Colony. Dr.Paul Lombardo assisted in this search, but no trace of a visit nor of correspondence could be found.

An interesting insight into what might be regarded as a small-scale, modern-day eugenics policy was recently experienced by the writer. During a visit to a school on one of the small outer islands of the Bahamas in 1995, she enquired what their policy was if a mentally retarded child on the island sought admission. The reply was that this had never happened. This was on an island with a population of six hundred persons, with an extremely high rate of inter-marriage. The Principal then added that if a child had severe abnormalities at birth no life support system or other aids would be used to prolong life, in fact, "the doctor might even give it a little injection." (Personal interview, 1995) The islanders were a deeply religious community; life on the island was simple, but in no way harsh. No hospital or institutional care was available for a severely handicapped person, therefore one assumes that, to the islanders, the best solution was not to prolong life.

#### h) Conclusions on the Issue of Feeble-mindedness 1918-1930s

In summation it would appear that the immediate post-Union period witnessed a change in focus in the field of mental health in South Africa. In pre-Union years efforts had been concentrated on committing the allegedly insane to asylums, either because they were judged to be in need of care, or, if they were considered violent, in order to protect the public.

Contemporaneous with the promulgation of Act 38 of 1916, in which mental deficiency was classified into seven distinct



categories, came the formation of the Commission in Mental Disorders. From the first report of the Commissioner in 1918 the focus of attention centered on feeble-mindedness. Not only was this condition recognised as the highest category of mental deficiency, but concern was expressed at the number of allegedly feeble-minded children within the community. At the crux of the issue was the perceived correlation between feeble-mindedness and the poor whites.

The lower grade mental defectives, confined to mental institutions were now virtually ignored, apparently because they represented no threat to the social structure of South Africa.

Because the feeble-minded remained within the community, yet were unable to contribute to the ethic of white supremacy, they were the group on which attention of government and medical authorities was to focus attention.

Until the end of the 1920s mental health authorities refused to acknowledge the existence of feeble-mindedness among any race other than white. Partial rectification of this situation was commenced in 1929, when the need to supply institutional accommodation for coloureds was perceived. The issue of feeble-mindedness in the black and Asian communities remained unacknowledged for some considerable time.

In the course of the present research the period, 1916 - 1930s, was found to be unique in the vilification of the feeble-minded in official documents worldwide. If the

terminology in current use is reflective of society's attitude towards persons with mental defects, then this period must be the nadir of the twentieth century.

It is suggested that it cannot be coincidental that this period of denigration occurred simultaneously with the worst economic depression the world has ever known. Mass unemployment begins at the lowest end of the social scale, with the unskilled and illiterate being the first to suffer. As unemployment permeates upwards accepted social structures are threatened or destroyed.

In South Africa in particular this vitriolic abuse was based on the perceived degradation of members of the white race. The Europeans, whether governmental bodies or individuals, witnessed members of their own race no longer able to maintain what were regarded as acceptable standards in their life-style. It appears likely that in generalising they saw people with little education, who were unskilled and perhaps of low intelligence, procreating further generations of feeble-minded progeny. Their reaction was to equate feeble-mindedness with poor whiteism, regardless of other possible etiology. Despite the findings of the Carnegie Report (1934) it appears that the perceived rationale frequently went as far as suggesting:

- a) All children of the poor whites are feeble-minded.
- b) With very rare exceptions all the feeble-minded children were progeny of the poor whites.

At times the official reports of the Commissioner in Mental Disorders, particular that dated 1918, read like a witch-hunt, with the feeble-minded as the victims. It will be recalled that this one report describes them as:

"A menace and a danger to society"

"...recruits to the ranks of criminals, prostitutes and vagrants"

"...detrimental to social order"

Perhaps the quote which most strongly epitomised the feeling of white South Africans was:

"...It is not difficult to foresee that drastic legislative measure may have to be taken to prevent mental degeneration in the white races of the country."

Report of the Commissioner in Mental Disorders (1918)

Although the provision of institutional care for feeble-minded children was advocated in the numerous reports this was seen primarily as a method of preventing the regeneration of the condition. It is clear that the central issue was always one of political and social significance, with the continued dominance of the white race being paramount.

It is suggested that the economic depression, and the drastic increase in the number of poor whites, provoked the fear among Europeans that white supremacy would decline.

Because the feeble-mindedness was seen as the self-perpetuating attribute, even in some cases the direct cause, of poor whiteism, this fear was manifest to some extent in verbal attacks on those least able to argue their cause, the feeble-minded.

It has been seen that in spite of demands for the control of the feeble-minded in single-sex institutions from 1918 and throughout much of the 1920s, the only State-funded institutions built in South Africa for this purpose appear to have accommodated patients of both sexes. The only single-sex institution was privately funded.

The emanation of the eugenics movement in the United States and in Germany was discussed in this chapter, although there would appear to have been little or no interest in its application in South Africa.

During the 1920s successive reports of the Commissioner in Mental Disorders (later known as the Commissioner for Mental Hygiene) show a growing awareness of the need to provide special residential facilities for children classified as feeble-minded, to segregate them from lower grade mental defectives and also from delinquents in reform schools. In the later reports special educational facilities are advocated for children unable to progress through the normal school system.

In 1928 the van Schalkwyk Committee was commissioned to enquire into the feasibility of such a project. The findings and recommendations of this committee will be among the subjects discussed in the following chapter.

## Chapter IX

### Provision for Children with Mental Handicap in South Africa

The previous chapter discussed the introduction of intelligence tests into South Africa and the resultant thrust into an extensive policy of identifying and classifying the allegedly feeble-minded. The appropriateness of the earliest I.Q. tests, when used in the South African context prior to 1927, has been questioned in the previous chapter. According to Minde (1975) it was only in 1927 that Fick produced standardised tests which were judged appropriate to local conditions and which placed a powerful diagnostic weapon in the hands of psychologists.

Chapter IX will discuss the facilities available in South Africa for the education, training and/or institutionalisation of mentally handicapped children. This discussion will cover all grades of mental disability, from the mildly handicapped to the severely retarded. The scope of the chapter will range from special schools to those children whose condition allegedly precludes them from deriving benefit from anything other than basic physical care. Finally the workshop facilities available for mentally handicapped school-leavers is examined.

It is hoped that this chapter will be able to assess where the priorities lie within the present system, i.e. with those considered educable, or those with very severe handicaps.

As stated in an earlier chapter the first reference to "imbecile children" in South African records occurs in the

report of the Physician-Superintendent of the Grahamstown Mental Hospital in 1918. This refers to the failure of the scheme to provide education and training which was initiated in 1894.

From that time there appears to have been a gap of some twenty years before the need to provide educational or training facilities for children with mental handicap was mooted again.

Although the Centenary Brochure for Town Hill Hospital 1880-1986 declares that there were eight children in the asylum in 1898 no mention is made of the availability of educational or training facilities.

It has been noted during the research for the present study that no evidence was found of child-patients being included among the so-called lunatics confined in asylums in South Africa prior to 1894. The inference is that mentally retarded children either died in infancy, or remained in the custody of their families regardless of the severity of their handicap until reaching adulthood.

From the second decade of the twentieth century mentally retarded children in South Africa begin to gain prominence in the reports of the Commissioner in Mental Disorders. The first report dated 1918 has been discussed in a previous chapter, and it will be recalled that a large portion of its content was devoted to the problem of children considered to be feeble-minded.

It is interesting to note that when attention did begin to focus on children regarded as mentally defective, around 1918, the main concern was on account of their perceived moral deficiency rather than their mental condition.

As stated in the previous chapter, these children were viewed as a social problem; as moral degenerates and as a potential threat to the continued supremacy of the white race in South Africa. The entire section of the 1918 report which deals with feeble-mindedness stresses the need to establish state control over those children classified as being in this category. Very little is said regarding the rights or welfare of the children themselves.

When intelligence testing was introduced into South Africa during the early 1920s the main impetus was, of course, directed at children of school age. Dunston (1918) reports that Drs. Leipoldt and Moll, having conducted tests (unspecified) in schools throughout the Transvaal, asserted that .84% of the children examined were feeble-minded.

This figure appears extremely low. Given the convention that most intelligence tests generally adopt a standard deviation of fifteen points, one would expect to find more than 2% of the population of any age group with an I.Q. between 55 - 70.

If a figure of below 75 I.Q. was taken as the level of feeble-mindedness the proportion would be 5%. Of these, the

vast majority would have been described as feeble-minded, with only a very small percentage falling into the more severe levels of the described categories.

Dunston argued that if the same percentage held good for the other provinces, the total number of defective children attending school would not be less than 3,000. It is obvious that Leipoldt and Moll seriously underestimated the number of children whose I.Q. would have fallen into this range.

Chapter VIII discussed the assertions by the medical profession that a disproportionately high percentage of the feeble-minded were a parasitic, degenerate class of potential criminals. Bearing in mind these allegations one might wonder whether such strong, pre-conceived beliefs led to a certain bias on the part of those conducting the tests, and if this was allowed to influence the results.

#### a) Categorisation According to Intelligence Testing

It will be recalled that the terms of definition in Act No. 38 of 1916 were imprecise, centering on the person's inability to manage himself or his own affairs, and his need of care, supervision and control. No apparent attempt was made to assess the level of intelligence.

As the movement towards mental testing gathered momentum in the 1920s the pendulum swung entirely towards identification



of the extent of handicap by I.Q. tests. By the time of the van Schalkwyk report, 1928-30, categorisation was presented in the following terms:

| <u>Category</u>         | <u>IQ Range</u>          |
|-------------------------|--------------------------|
| Idiots                  | Below 25                 |
| Imbeciles               | 25-45, border zone to 50 |
| Feeble-minded or morons | 45-60, border zone to 75 |
| Subnormal:              |                          |
| innate                  | 60-80                    |
| borderline              |                          |
| Dull normal             | 80-90                    |
| Average                 | 90-110                   |
| Bright                  | 110-120                  |
| Talented genius         | Over 120                 |

Van Schalkwyk indicates educational potential as follows:

| <u>Category</u>         | <u>Description</u>                                                                                                                |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Feeble-minded or morons | Legally certifiable as mentally defective, uneducable in scholastic sense                                                         |
| Subnormal               | Not legally certifiable, demarcated by psychological and pedagogical criteria, permanently incapable of completing primary school |

| <u>Category</u>                                    | <u>Description</u>                   |
|----------------------------------------------------|--------------------------------------|
| Dull Normal                                        | Capable of completing primary school |
| Remaining categories                               | Normal schooling                     |
| (van Schalkwyk Committee report 1928-1930 p.36-39) |                                      |

It will now be seen that the mentally handicapped were being identified, compartmentalised, and labelled to a far greater extent than hitherto. It may be argued that this labelling was of benefit to all concerned, enabling the administrators to become aware of the extent of problem areas, and consequently bringing benefit to those bearing the labels.

In effect such a system appears to have brought few benefits to those at the lower end of the intelligence scale. The perception was that any child with an I.Q. of less than 75 was ineducable, and need only be provided with "care and training". The pronouncement that a child had an I.Q. of below 75 destined the child to a life of virtual mental stagnation. There was to be no attempt to develop any latent abilities, nor to assess their potential. It is doubtful whether they were considered to have either abilities or potential.

Those with an I.Q. of under 80 were considered incapable of completing primary school education and were judged to be candidates for special education. This chapter will later examine the extent of these facilities in the early 1930s, at the time of the Van Schalkwyk report.

Dunston (1918) and Malherbe (1932) agree that one of the diagnostic problems facing the medical profession was to distinguish between the clinically feeble-minded child and one who was temporarily retarded, i.e. those who were handicapped by starting school at a late age; by poor health; malnutrition; defective sight or hearing; frequent changes of school, or irregular attendance. The difficulty of producing reliable statistics was exacerbated by this problem. It is frequently unclear whether statistics refer only to the feeble-minded or whether they include children regarded as temporarily retarded.

#### Early Provision for Mentally Handicapped Children in South Africa

One of the earliest proposals for special classes or special schools for mentally defective children comes, not from a governmental source, but from the South African Society for the Care of the Feeble-minded in 1913. (Cited in Vitus, 1987 p.15) At their inaugural meeting in Cape Town their stated aims were:

"To educate public opinion with regard to the necessity for the protection and care of feeble-minded persons; to gather information and statistics, and to undertake a comprehensive investigation with a view to providing for the care and training of such persons.

To press upon educational authorities throughout the country the necessity for establishing separate

classes and schools for defective and backward children.

To establish such homes or training institutions as may be needed for feeble-minded children; to seek Government help and co-operation in our work; to secure legislation whereby inmates of other institutions, such as reformatories and asylums, may be transferred to proper training institutions for the care of the feeble-minded."

It will be recalled from the previous chapter that the first report of the Commissioner in Mental Disorders (1918) also stressed the need to remove the feeble-minded from reformatories and asylums. If the government ever became aware of the aims of the South African Society for the Care of the Feeble-minded, some five years earlier, it would appear that little action had been taken.

It would appear likely that the Society was the earliest organisation in South Africa to appeal for nationwide provision of education for "defective and backward children."

Unfortunately the enlightened approach advocated by the Society in Cape Town was not immediately followed through. This may have been due to the outbreak of World War I the following year, when it is likely that many building projects were put in abeyance.

In the event, it was to be 1921 before the first institution for the training of the feeble-minded was opened in South Africa. This was the state-funded Alexandra Institution in Cape Town.

In 1918 Dunston estimated a total of 3,000 feeble-minded children were attending normal schools throughout the Union. As feeble-mindedness was not recognised in any other race, this number must refer only to white children.

Throughout the early years of his tenure as Commissioner in Mental Disorders Dunston repeatedly requested the removal of feeble-minded children from normal classrooms because of "the time wasted on them" (1918 p.14) Nowhere in his successive reports does Dunston indicate whether these requests were motivated by public opinion. It may be that allegedly feeble-minded or scholastically backward pupils, as a result of academic inadequacy, were disruptive, or that the teacher experienced difficulty in completing the required syllabus if much time was occupied with the slow learners. It would have been interesting to have read reports by teachers or inspectors of schools indicating these or other problems, but no such documents could be traced.

The first legislation to provide for the education of certain types of mentally handicapped persons was the Vocational Education and Special Schools Act No.29 of 1928. According to Davis & Foster (1990 p.242) this Act was intended to provide educational facilities in special classes or special schools for the category of mildly handicapped then

known as "subnormal" in contrast to the "feeble-minded" and "mental defectives". It will be seen that the scope of this act was severely limited, yet it was to remain in force for twenty years, only being replaced by the Special Schools Act No.9 in 1948.

The earliest traceable statistics showing the number of special classes and special schools are for 1929 and illustrate the inadequacy of the special education system:

|                        | Sp.schools. | Sp.classes |
|------------------------|-------------|------------|
| 1929 Orange Free State | 0           | 0          |
| Cape Province          | 0           | 3          |
| Transvaal              | 0           | 8          |
| Natal                  | 1           | 2          |

#### The de Vos Malan report (1945)

According to the same source the accepted quotas in each case were:

- a) a quota of 10/12 pupils for special classes in the Cape Province; Transvaal and Natal
- b) 104 pupils for special schools in Natal

It appears that the Orange Free State held rigidly to the quota of 15 pupils for special classes, as originally suggested by the Secretary of Education in connection with his

system of subsidies. The difficulties of assembling sufficient children to meet the quota for special education in areas where the rural population was sparse and widely scattered is mentioned in another section of the report. It may be that this accounted for the absence of special classes in the Orange Free State in 1929. One may also conjecture that had this province brought their quota into line with the other provinces they may have been able to establish special classes for the children needing them.

One might question the wisdom of adhering so strictly to the original quota, when the other provinces did not. It may perhaps be suggested that the Orange Free State education authorities were reluctant to embark on special education and that this was a means of deferring that action.

The given quota of pupils for special classes in the Cape Province, Transvaal and Natal was 10/12. Taken at the higher quota of 12 pupils per special class, and the Natal figure of 104 pupils per special school, the above list gives a total of 260 children throughout the Union who were provided with special education in 1929, eleven years after Dunston identified the extent of the problem.

Accepting Dunston's figure of 3,000 children in need of special education in 1918 and allowing for a normal increase in these numbers commensurate with the rising population, the percentage of pupils placed in special education can only be regarded as infinitesimal. The fact that the nation was, in common with most other western countries, passing through a

period of economic depression does not mitigate the fact that special education was clearly regarded as among the least important area when educational priorities were considered.

It will be recalled that the period during which lunatics were accommodated on Robben Island, 1846-1891, was characterised by the government establishing commissions to enquire into conditions on the Island, then failing to act on their recommendations. Much the same could be said about the position regarding the education and training of feeble-minded children between 1916, when the category of feeble-mindedness was recognised in South Africa and 1930s. There was a proliferation of reports, as stated below, but very little action.

It has already been stated in the previous chapter that successive reports from the Commissioner in Mental Disorders between 1918 and 1925/26 called for the removal of feeble-minded children from ordinary schools and from reformatories, and their placement in special schools or special classes.

In 1926 the Witwatersrand Juvenile Affairs Board appointed a standard sub-committee to investigate "the disposal of certain types of boys and girls they regard as unemployable" due to low intelligence. This sub-committee subsequently submitted proposals, including the need for a government inquiry into the area of the mentally retarded, to both the Department of Labour and the Department of Union Education without any meaningful results. (Foster 1990)



The Vocational and Special Schools Act of 1928 was followed by the appointment of the Inter-departmental Committee on Mental Deficiency which resulted in the van Schalkwyk report of 1930.

It would appear that both the sub-committee of the Juvenile Affairs Board and, two years later the Inter-departmental Committee on Mental Deficiency, made analagous recommendations for a comprehensive programme for the identification, registration and control of mentally defective children. Each recommendation appears to have led to the formation of yet another committee, but very little action.

It has been mentioned earlier that the education of mentally retarded children appears to have been extremely low on the list of educational priorities. Such a suggestion can only be reinforced by reading the section on special schools contained in the Report of the Union Department of Education for the calendar year 1936. No mention is made of special schools or special classes for the mentally handicapped. The entire emphasis is on schools for the blind and deaf. The only reference to any impairment beyond these is the statement that a State-aided school for epileptics had been opened that year in Kuilsrivier and catered for ten children. Prior to this no record of separate educational facilities for epileptic children could be traced.

The Increase in Provision for Mentally Handicapped Children in  
South Africa

In 1945, fifteen years after the van Schalkwyk report, the Inter-departmental Committee on Deviate Children submitted an extensive report in which it made clear that the expectations of the Special Schools Act of 1928 and the van Schalkwyk report of 1930 had not been fulfilled and that the educational provision for mentally handicapped children remained totally inadequate. Foster (1990)

The van Schalkwyk report (1930) had strongly recommended special schools in preference to special classes, but this counsel was over-ruled, presumably because of the heavier costs involved. No figures were available of comparative costs for that period, but based on present day calculations the difference was likely to have been substantial.

In 1936 the Secretary of Education notified provincial administrations of the basis on which subsidies for special education would be granted. The present authorities were unable to produce a record of the amounts of these subsidies during the 1930s, they could only affirm that the bias was towards special classes.

While such a policy suggests that the Secretary viewed this issue purely from a monetary perspective and calculated the subsidies accordingly, it should be added that at the present time parental preference appears to be for special classes

over special schools in the education of children with mental handicap.

Personal interviews with parents of mentally handicapped children in South Africa and in the U.K. during the 1990s indicated a marked preference for the placement of their mentally handicapped child in a special class attached to a ordinary school. The overwhelming feeling was that less stigma was attached to inclusion in a special class rather than in attending a special school. For many parents attendance at a special school would have necessitated the child living away from home, and this weighed heavily in favour of special classes.

One might question whether parental preference would have been a deciding factor in governmental decisions in the 1930s. There is no indication, from available records, that the concerns of the parents were canvassed by those who drafted the regulations.

The de Vos Malan report (1945) affirms that the Secretary of Education was to continue to offer considerably higher subsidies to special classes than to special schools, but once again no statistics are supplied. It will be noted that one of the two special schools shown in the 1937 list had apparently been closed before the 1943 records were compiled.

One must assume that these children had been transferred to special classes.

|                        | Sp. Schools | Sp.classes |
|------------------------|-------------|------------|
| 1937 Orange Free State | 0           | 7          |
| Cape Province          | 0           | 41         |
| Transvaal              | 2           | 22         |
| Natal                  | 1           | 2          |
| 1943 Orange Free State | 0           | 29         |
| Cape Province          | 0           | 225        |
| Transvaal              | 1           | 38         |
| Natal                  | 2           | 6          |

de Vos Malan Report (1945)

The number of special classes grew from 13 in 1929 to 298 in 1943, but commensurate with this came an increase in the number of children regarded as requiring special education. Malherbe (1932) stated that out of 348,808 pupils in the Union 44,000 (12.77%) were retarded by two or more years. The term "retarded" for statistical purposes is used as synonymous with "too old for standard".

The widely differing statistics purported to refer to children in need of special education between 1918, when the earliest estimates were made by Dunston, and those quoted for 1937 in the de Vos Malan report (1945) are of interest. Dunston estimated there were 3,000 children in the Union in need of special education in 1918. As the process of

identifying children regarded as either feeble-minded or scholastically retarded was then in its infancy in South Africa one may assume that Dunston seriously underestimated the problem. One must, however, doubt whether his calculation was as inaccurate as Malherbe's figure would suggest, when he estimates the number to be 44,000 children in need of special education in 1932. Even allowing for the accepted increase in population and the improved methods of identifying those in need, such a difference between these two estimates would appear exceptionally large. It may be that Dunston was excluding children regarded as scholastically backward, while Malherbe was including these, but even so there would appear to be a considerable discrepancy in some of the figures.

The figures taken from the de Vos Malan report of 1945 would appear to be even lower than those of Dunston. The breakdown into provinces is given below:

Children in need of Special Education by  
Virtue of Mental Handicap

|      |                                |       |
|------|--------------------------------|-------|
| 1929 | No statistics for any province |       |
| 1937 | O.F.S.                         | 111   |
|      | Cape                           | 719   |
|      | Transvaal                      | 523   |
|      | Natal                          | 155   |
|      |                                | ----- |
|      |                                | 1,508 |

|      |           |       |
|------|-----------|-------|
| 1943 | O.F.S.    | 400   |
|      | Cape      | 3,414 |
|      | Transvaal | 837   |
|      | Natal     | 340   |
|      |           | ----- |
|      |           | 4,991 |

#### de Vos Malan Report (1945)

The whole issue of scholastic retardation is problematical, relating as it does to the curriculum and adult expectations of the child's achievements. Consequently, whatever estimates are made will reflect the attitudes and priorities of the officials rather than some precisely measurable dimension of the children.

It will be seen that the number of special classes among the provinces was disproportionate. Initially it would appear that the number of children in the Cape requiring special education exceeded the other provinces by an astounding degree.

The de Vos Malan Report (1945) asserts the reasons for this small number of special classes outside the Cape Province to be:

- a) no trained teachers available in some provinces
- b) no qualified psychologists to conduct tests

- c) insufficient candidates in sparsely populated areas to make up quota for special classes, i.e. 15 in O.F.S.; 10/12 in other provinces

The report further mentions that the Cape Province conducted group tests much more extensively than the other provinces, thus making more rapid development possible. One should perhaps question the effectiveness of group testing as opposed to individual tests, given the wide disparity of the statistics. Fick (1929) states that group testing should be seen as a sifting process. Children who performed badly in group testing should then be tested individually. There seems no evidence of this being applied in the Cape Province.

The Cape was also the first province to make provision for the training of teachers for special classes and for the appointment of a larger staff of psychologists than any other province, according to the de Vos Malan Report (1945). No reason is stated for this, but it is interesting to find the Cape in the forefront of this field.

It was not the first time that the Cape authorities appear to have had a greater perception of the needs of the mentally handicapped. It will have been noted from earlier chapters that by the close of the nineteenth century the Cape had provided a total of five asylums throughout the colony (including Robben Island), while each of the other territories provided only one apiece. Table II in the addendum to Chapter V shows that, while the Cape Colony had by far the highest

population by 1900, this was not proportional to the provision of beds in asylums.

It has also been mentioned earlier in this study that the Cape was the first of the provinces to establish an institution for the care and training of the feeble-minded in 1921.

One may only conjecture the reason for the Cape being in the forefront of intelligence testing and the training of psychologists and teachers in the area of special education. The earliest medical practitioners specialising in mental disorders in South Africa were those who settled in Cape Town during the nineteenth century. It might be suggested that they established a certain reputation for work in this field which grew with the passage of time and spread to the area of training for those wishing to work in the field of mental health.

Research conducted into the Acts and reports of Commissions on the education of the mentally handicapped reveals a certain anomaly. The Special Schools Act No.9 of 1948 (p.50) states:

"Special school" means a school in which handicapped children receive special education, either on a full-time or part-time basis, and includes a special class attached to an ordinary school."

It has been stated earlier in this chapter that the van Schalkwyk report of 1930 had recommended special schools over special classes and that this counsel was over-ruled



by the Secretary of Education. The 1948 report, quoted above, would suggest that "special school" was to be used as a comprehensive term to cover both facilities, regardless of the fact that special classes outnumbered special schools 370 to 6. de Vos Malan report (1945) At best the use of "special school" in this context is a misnomer, at worst it is an overrepresentation of the facilities available.

It was shown in Chapter VIII that there were two main problem areas in public perception of feeble-mindedness during the 1920s:

- a) Because of their low intelligence the feeble-minded were considered unemployable, a factor which led to degeneracy socially and morally in the eyes of the white population.
- b) Because of the problem of the regeneration of feeble-mindedness.

By the 1940s a change in perception is apparent.

- a) The term "feeble-minded" has been replaced in the de Vos Malan report by "mentally handicapped child".
- b) The focus is on the training of males in useful occupations on the assumption that they

will earn a living in the open labour market.

- c) The training of females on the assumption that most of them will marry and become parents.

The change in attitude over a thirty year span is of considerable interest here. The training advocated is based on the assumption that these high-grade retardates will take their place in the job market, albeit in the lower paid sector, and will marry and raise families of their own.

In 1918, only thirty years prior to the de Vos Malan report, the feeble-minded were being assessed as morally defective, incapable of self-support, and a menace to society. Dunston was stressing the urgency of control, and advocating removal to single sex industrial or farming institutions in order to stop the procreation of future generations of morons.

Although this transformation of attitude may have been due to a burgeoning realisation within society that those formerly labelled feeble-minded had the right to a life of normalcy, it is theorised that a more likely reason lay elsewhere.

During the Depression, with its unprecedented levels of unemployment, the joint problems of poor whiteism and feeble-mindedness were perceived as a threat to the fabric of white South African society.

Then, at the end of 1932, the decision was taken by the Government to depart from the gold standard. Despite fears to the contrary, this action brought South Africa out of the Depression ahead of most western nations. Davenport (1991)

A stronger economy leads to a proliferation of jobs. In 1939 the outbreak of World War II created an even greater need for all available manpower. Unemployed men of normal intelligence were no longer competing for lowly paid unskilled work. It therefore became expedient to offer such employment to those whose mental capacity was adequate for such tasks, but who might be incapable of functioning at a higher level.

It may be suggested that black labour could have been used in preference to mentally handicapped whites, but the job reservation scheme was still in operation, and whites of any mental calibre took precedence over blacks.

#### e) Provision of Special Education for Non-Europeans

It will have been noted that none of the aforementioned Commissions and legislative Acts makes any mention of race. Statistics have shown that educational facilities available were totally inadequate for the number of children considered to require special education. When one realises that such facilities were the prerogative of the whites alone then the shortage assumes immense proportions.

1948 was a watershed in South African politics, with the electoral victory of the National Party and the ushering in

of the apartheid era. Although a discussion of politics is beyond the scope of this thesis it was felt that a brief mention of the pertinent legislation should be made at this point.

After a lull in legislative activity in the area of mental health during the 1950s, the focus on special education for the feeble-minded expanded during the 1960s when a series of legislative Acts along racial lines were promulgated.

Notable among the legislation of the 1960s were three education Acts:

The Coloured Persons Education Act No.47 of 1963

The Indians Education Act No.61 of 1965

The Bantu Special Education Act No.24 of 1964

The wording of Act No.47 of 1963 and Act No.61 of 1965 was practically verbatim to the Special Schools Act No.9 of 1948 which had applied solely to white children.

In the case of Act No.24 of 1964 the wording was significantly different. This act was only to apply to black children judged to be in need of special education on account of blindness, deafness, epilepsy or any other physical defect. It was apparent that mentally handicapped black children were to remain excluded from the system of special education.

Special education was only introduced for black mentally retarded children with the Education and Training Act No.90 of 1979, providing for both the educable ("handicapped") child and the trainable ("mentally handicapped") child. In 1986 Act No.3 amended the latter category to "mentally severely handicapped child" (Sic).

The outcome of these Acts will be discussed in the following chapter.

f) The Establishment of Training Facilities for the Ineducable

Prior to 1967 legislation appertaining to children with mental handicap had been concerned only with the high-grade mental defectives, those regarded as educable. Grover (1990 p.165) describes the philosophy underlying the educational policy for the more severely mentally handicapped child as overly pessimistic:

"hence the major emphasis in management was placed on physical safety and the employment of sufficient restraining measures to ensure that the child might not become a danger to other persons or property."

It is Grover's assertion that a policy which is purely custodial results in children existing in a restrictive and sterile environment, cut off from the normal world and offering little opportunity for progress or behavioral change. Such deprivation frequently leads these children to develop secondary retardation which is then seen by the staff as confirmation of the original diagnosis rather than the result

of institutionalisation.

Theoretically the turning point for the more severely mentally handicapped emerged from the findings of The Committee of Inquiry into the Care of Mentally Deficient Persons, more popularly known as the van Wyk Commission, in 1967. This report represented a breakthrough in the provision of training facilities for the lower grade mentally retarded children, hitherto ignored. It stated that the mentally handicapped child with an I.Q. of below 50, if at all able to benefit from it, had the right to a state-funded training from the age of six to eighteen years.

This committee was appointed under the auspices of the Department of Health to investigate and assess the field of mental handicap, focusing in particular on the more severely retarded. The report made a total of twenty-six recommendations, concentrating chiefly on the areas mentioned below:

- a) that private welfare organisations take the initiative in creating an organisation to co-ordinate, direct and stimulate services for mentally handicapped persons.
- b) that compulsory training be provided for "trainable" children between the ages of six and eighteen years and that the Department of Education, Arts and Science be responsible for the financing and control of privately administered training centres and training centres at state institutions.

- c) that the subsidisation and control of protective workshops to be provided for mentally handicapped persons above the age of eighteen years be the responsibility of the Department of Social Welfare and Pensions.
- d) that holiday homes and social clubs for mentally handicapped persons be the responsibility of private welfare organisations
- e) that assessment centres and centres for genetic counselling be established
- f) that the Department of Health retain responsibility for the care of severely and profoundly mentally handicapped persons

Department of Health (1967)

According to Vitus (1990) the recommendations contained in the van Wyk report were only released by Dr. Albert Hertzog, who headed the Department of Health at that time, after a delay of two years.

It is suggested that the most likely reasoning behind this delay was inter-departmental feuding at governmental level and what may best be described as "political empire-building".

The appointment of the van Wyk Committee had been made by the Department of Health. Now their recommendations were that the responsibility for mental health services should be spread among other departments:

- a) that private welfare organisations play a more active role.
- b) that the proposed compulsory training of "trainable" children should fall under the aegis of the Department of Education, Arts and Science.
- c) that the recommended protective workshops be the responsibility of the Department of Social Welfare and Pensions.

Although the final recommendation in the report was that the Department of Health should retain responsibility for the care of severely and profoundly mentally handicapped persons, it will be seen that Hertzog's department was being asked to cede a substantial proportion of their authority to other departments. It is suggested, therefore, that Hertzog delayed the official release of the recommendations of the report as long as possible in order to postpone what he considered a diminution in the sphere of influence previously enjoyed by the Department of Health.

According to Foster(1990) the Department of Education found that the Education Services Act No.41 of 1967 did not provide for state-aided training centres for the mentally retarded to be financed on the same basis as schools for physically disabled children, as recommended in the van Wyk report, and that enabling legislation was necessary. The appropriate legislation, was to follow in 1974 in the form of the Mentally Retarded Children's Training Act No.63.



Unfortunately this Act also resulted in further restrictive labelling. Moderately or severely retarded children with an I.Q. of between 49 and 30 were classified as trainable but not educable.

Before discussing the facilities which were made available under this latest piece of legislation it would be useful to enquire into the reasoning behind this policy change. Prior to the 1974 Act, legislation in South Africa had provided education for mentally handicapped children only if they fell into the category of mildly handicapped. Act No.63 allowed for the training of children with more severe forms of handicap for the first time. One may conjecture that this change in perception was influenced, in no small part, by developments internationally, including the actions of the United Nations. Throughout Europe and America during the 1960s/70s interest was focused on the moderately and severely mentally handicapped. Increased funding was being provided for the improvement of educational facilities for the mentally handicapped and new laws were being implemented. Grover (1990)

In 1968 UNESCO had declared that year as the International Year of Human Rights. This was followed in 1971 by the United Nations General Assembly proclaiming the Declaration of the Rights of Mentally Retarded Persons. This document declared these rights in the following terms:

"The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other occupation to the fullest extent of his capabilities.

Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with whom he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should be necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities."

Although such a document represented a considerable advance in societal perception of the rights of the mentally retarded, in the view of Hattingh et al (1987) this Declaration is worded in such a way that it is no more than a policy document and has no legally enforceable advantage for the disabled.

Act No.41 of 1967, the Educational Services Act, provided for the education of mentally handicapped children classified as educable, while Act No.63 of 1974 provided facilities for the more severely retarded, those regarded as trainable not educable. These categories of handicap, dividing children who were considered educable from those who were not, had been regarded as functionally separate since they were laid down in the van Schalkwyk report in 1928-30.

Under South African law the provision of special schools for the higher grades of mental handicap and the provision training facilities for the lower grades were covered by separate legislative acts until 1988.

S.A  
act

Act No.70 of 1988 appears to mark a shift in attitude. This Education Affairs Act was promulgated to amend Act No.41 of 1967 and Act No.63 of 1974 mentioned above, and includes all handicapped children in one category:

" ... "handicapped child" means a child who in the opinion of the Head of Education is able to benefit from a specialized education programme for handicapped children, but who deviates to such an extent from the majority of the children of his age in body, mind or behaviour that he -

- (a) cannot benefit sufficiently from the instruction provided in the ordinary course of education;
- (b) needs specialized education to facilitate his adaptation in the community; or
- (c) should not attend an ordinary class in an ordinary school, because such attendance may be harmful to himself or to the other pupils in such a class;"

The inclusion of the final phrase "may be harmful to...the other pupils in the class" raises the question of where the priorities of teaching staff should lie in the event of disruptive behaviour on the part of the handicapped child. One might question if the responsibility of the class teacher would be to the class as a whole or to the integration of the handicapped child should he not respond to reasoning. It is apparent that a teaching aide for the handicapped child would be indispensable in such a situation.

The inference is that the term "handicapped child" used in Act No.70 of 1988 refers to all mentally or physically handicapped children regardless of the nature or the degree of the handicap. It is interesting to note that the use of an inclusive term in this act illustrates a reversal of Act No.38 of 1916 when the division of mental handicap into categories was regarded as an important breakthrough in the area of mental health.

g) National Survey of Facilities for Persons with Mental Handicap by the National Council for Mental Health 1985

The stated objective of the survey was to facilitate the appropriate planning, monitoring and provision of services for persons with mental handicap by establishing the areas of greatest need.

The present study has already discussed the special classes and special schools for the mildly handicapped. It was felt that consideration should also be given to the amenities that were becoming available for the more severely mentally handicapped.

The purpose of including such a section in this thesis is to illustrate the perceived needs of persons with severe or moderate mental handicap in South Africa in the mid 1980s.\_

(i) Definition of Facilities Available for Moderately and Severely Handicapped Children in the Mid 1980s.

Special Care Centre: Day or residential centre catering for profound and severe range of intelligence. Officially labelled "untrainable".

Training Centre: Catering for upper severe through to moderate intelligence and in certain cases exceeding this level. Officially labelled "trainable".

Work & Occupation Centre: Protective workshops and other settings, both day and residential, providing regular employment for mentally handicapped adults.

Facilities Available in the mid-1980s:

Special Pre-Schools, Ages 0-7years:

3 pre-schools for whites, total of 72 children

185 children under the age of 5 years in training centres: 176 white; 8 Indian and 1 black.

Training Centres, Ages 5-19 years:

3,509 whites and 1,454 blacks in training centres

**Projected Needs: Natal 222 places for Indians**

W.Cape 1,304 places for coloureds

E.Cape 185 places for whites (only area with shortage of space for whites.)

Special Care Centres, Ages 0-6 years;  
7-21years;  
22+years

White 84% of the needs were met  
Black 14.4% of the needs were met

Projected Needs: 9,378 places for blacks  
1,476 places for coloureds  
809 places for Indians  
702 places for whites

Almost all of these centres were residential, with few day centres.

Work & Occupational Centres, Ages 20-60years

Projected Needs: 3,880 places for whites  
3,153 places for coloureds  
1,071 places for Indians  
408 places for blacks

Total number of facilities included in this survey was 232:

124 for whites  
48 for coloureds  
47 for blacks  
13 for Indians

It should be noted that the "needs" stated above were those perceived by the National Council of Mental Health in 1985.

It is suggested that the figures for the black racial group in particular fall far short of reality. The statement that only 408 places for mentally handicapped blacks were needed in work and occupational centres would indicate a gross under-identification of the numbers in need.

Figure I indicates the availability of facilities for persons with mental handicap in South Africa in 1985, with divisions according to race:

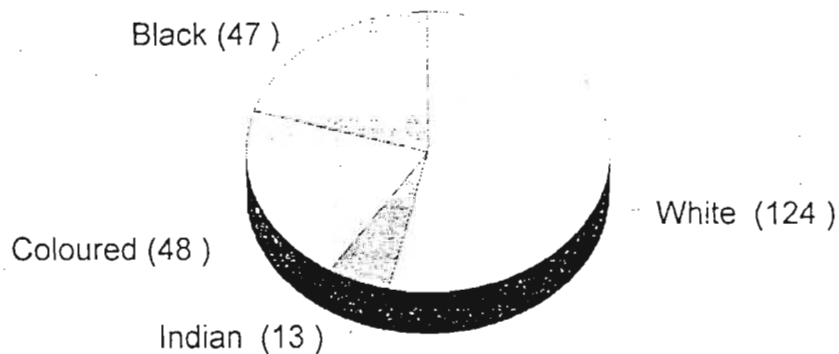


Figure 1. Facilities for people with mental handicap, according to race.

Data from Y. van der Westhuizen. (1990)

According to the survey in 1985 the white population was 4,563,139. Although the survey did not provide population statistics for any other racial group these were obtained from the South African Statistical Services Report and are given below:

|                           |                |
|---------------------------|----------------|
| Total Population for 1985 | 27,241 million |
| White                     | 4,867 million  |
| Coloured                  | 2,986 million  |
| Asian                     | 902 million    |
| Black                     | 18,486 million |

These figures exclude the Homeland states.



It will be noted that diagrams, Figures 2 and 3 are in almost reverse proportions to each other.

Figure 2 shows the percentage of needs already met in each race group; while Figure 3, illustrates the number of mentally handicapped persons still in need of facilities. The graph shows the whites having the highest proportion of needs met and being the least in need. The blacks are shown with the lowest proportion of needs met and the highest proportion of needs outstanding.

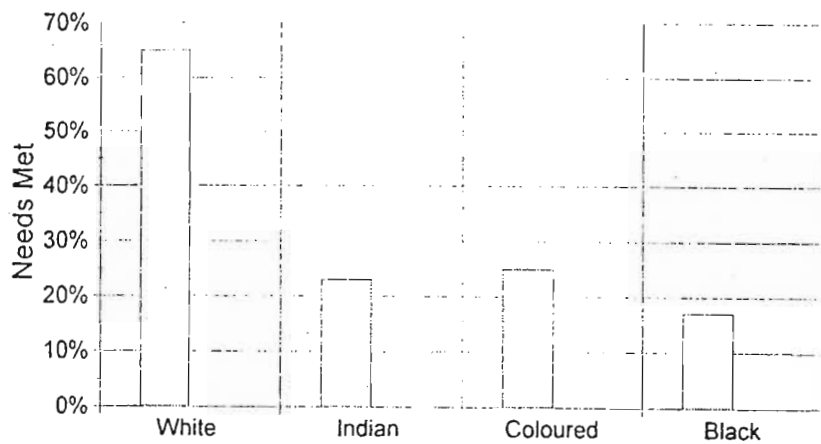


Figure 2. Percentage of needs met, according to race.

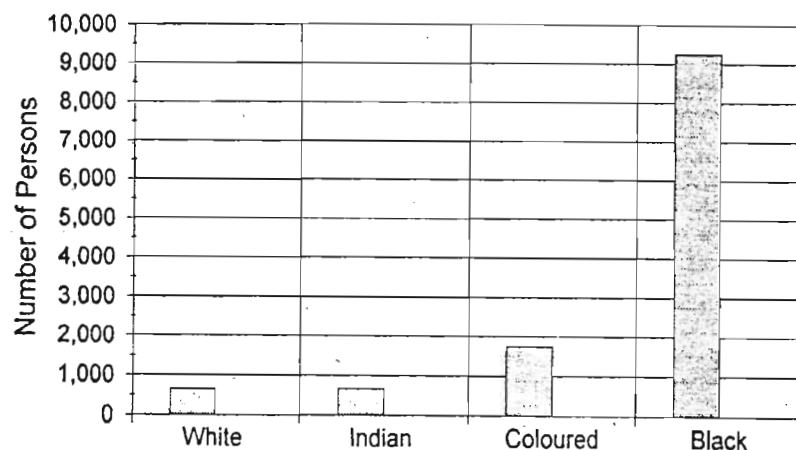


Figure 3. Number of persons in need of special care facilities, according to race.

Data from Y. van der Westhuizen (1990)

The overwhelming perception is that while the mentally handicapped of any race were disadvantaged, black mentally handicapped persons were doubly so. The following section will attempt to explore the changes brought about during the 1990s under the Democratic Government.

Special Educational and Training Facilities Available in Post  
Apartheid South Africa.

Under the new Democratic Government South Africa is divided into nine provinces in place of the original four. The re-alignment of boundaries, plus the inclusion of the former "homeland" territories has placed considerable stress on the educational administrative services during the 1990s. Added to this is the fact that the administration of educational services now falls under one department, the National Department of Education, which replaces the four racially based Departments of Education and Culture of the apartheid era.

The difficulty of obtaining statistics during this time of transition was severely underestimated. Repeated telephone calls, facsimiles and postal enquiries elicited so small a response that a compilation of figures would have been meaningless. It has therefore not been possible to include information on the perceived needs of facilities for the mentally handicapped in order to make a comparison with the 1985 figures. One might hope that when such statistics become available they will show a more realistic perception of the needs of persons with mental handicap in the black communities than was shown in 1985.

Facilities for Mentally Handicapped Persons Over School Age.

Until comparatively recently the needs of the mildly mentally handicapped adult in South Africa were largely ignored. A new awareness of this need by Mental Health Societies has resulted in the provision of much-needed protective workshops and farms. Once again it was not possible to obtain figures nationwide, so the overview is generalised and no statistics can be given.

Personal interviews and observations at workshops in Natal during the mid-1980s and again ten years later indicate substantial changes. During the mid-1980s contract work was scarce and the centres were reliant on the same few regular customers. Frequently the young people were under-employed, which resulted in frustration and boredom. When work was available it was inevitably a repetition of jobs undertaken in the past.

By the mid-1990s a meaningful change in both the quality and the quantity of work undertaken on these premises had taken place. In no small measure this was due to increased training programmes for the workers, allowing them to branch out into the hitherto unexplored areas of furniture repairs and certain forms of contract work which required slightly more skill than in the past.

The centres were receiving numerous orders for the repairing of furniture. Their customers vouch for good quality work, reasonably priced. Although the repairs may

take longer than if undertaken commercially, the promised delivery date is invariably adhered to. The commercial firms willing to contract-out jobs on a regular basis is growing steadily. This results in full occupation of those employed and provides more variation than in the past.

The observable results have been a higher degree of motivation and morale among the mentally handicapped workers. Although their tasks essentially remain uncomplicated the variety in the contract work has engendered a sense of pride in their newly acquired skills. A new sense of purpose is apparent in the workshop. Many are achieving a genuine sense of job satisfaction. They are proud of earning a wage, however small that might be, and feel they have become part of a work-force.

Sheltered workshops are, for the most part, situated in urban areas, but mental health societies are currently increasing the number of sheltered farming schemes for young adults with mental handicap. These schemes provide residential accommodation for the participants. Initially aimed at becoming self-sufficient, the ultimate goal is the ability to compete in the market-place.

Although situated in rural areas, these schemes are not, at the present time, catering for mentally handicapped persons among rural communities. Currently the residents have all be translocated from urban institutions.

According to the mental health societies involved, results on the established farms are positive. In the case of recently established farms, such as Sunnyside Protective Farm at Bulwer, Natal, it is considered too early to evaluate the long term prospects.

It is ironical to note that during the 1960s in England it was government policy to sell off farms belonging to mental institutions on the grounds that allowing patients to work on the land constituted enforced cheap-rate labour. Whilst on the staff at The Towers Hospitals, Leicester, the writer recalls many patients complaining about this decision. Not only did they enjoy the work, but they were able to spend their days outside the hospital wards.

Many of the hostels funded by mental health societies try to emulate, as near as possible, a home-like atmosphere. The extent to which this is successful is dependent to a large extent on staff. Unfortunately the staff turn-over in these hostels is high, and many staff are untrained and frequently unsuitable for the role they are asked to play. Accommodation was found by the writer to be of a high standard. Although sporting activities were usually negligible, entertainment in the form of television, weekly videos and a monthly disco were often provided.

At the present time the demand for places in hostels and in the farming communities far exceeds the vacancies available. It would appear that many branches of the National Council of Mental Health are currently experiencing adequate funding in the form of subsidies and several new projects are in the pipeline.

It appears from numerous interviews with workers in the State sector of mental health that their over-riding concern is whether the new government will provide sufficient funding to allow for the continuance of service provision. Their

projections are that all the present facilities will need to operate at increased capacity in order to tackle the areas of neglect emanating from the past.

The teachers at special schools and the staff at state-controlled residential institutions are, overall, pessimistic about the future. They feel that the financial cut-backs they have experienced, coupled with severe delays in the payment of subsidies, do not auger well for their future.

On the other hand similar concern is less apparent in the mental health societies. The two societies interviewed in Natal were experiencing no reduction in state-funding and were very optimistic about their future.

Unfortunately this thesis will be concluded before the policy of the present government towards funding in the area of mental health is evident.

Regarding the small privately funded homes, such as the Sunfield Homes in the Transvaal and in Natal, these were found to be relatively few nationwide, with each having lengthy waiting lists. Because of the high cost to parents and the strictures such homes place on applicants, it was felt that their role was minor in the over-all scene.

Because of the high demand for places these homes can afford to be selective. Those contacted by the writer refuse to accept persons with moderate to severe retardation, or any mildly handicapped person with an additional physical handicap. Although such institutions are intended to provide life-long care, those visited had been operating for relatively short periods, and consequently all their residents were comparatively young.

Most of the privately funded homes visited were found to be comfortable and pleasant, with well-motivated and caring staff. Residents were occupied in workshops for a certain number of hours each day, sporting activities were encouraged and a reasonable amount of entertainment was provided in most of these institutions.

As already stated, it was felt that the role of these homes in the provision of accommodation for mildly retarded persons is likely to remain minor. Although the fees at the present time are already high, most of the staff interviewed stressed that they are already struggling to maintain their standards in the face of the spiralling cost of living. It remains to be seen how many will survive in the future.

Whilst most of the small privately funded homes visited provided a good level of care, mental stimulation and physical activity, some were seen as less satisfactory. The material comforts always appeared to be adequate, the perceived problem was the failure of the staff to relate in a meaningful way to the young residents. The youngsters received no mental stimulation, neither did they appear to be challenged, either physically or intellectually. They had minimal occupation, and little in the way of entertainment. It is suggested that suitably qualified and motivated staff are of prime importance in any institution.

Parental contact appeared to be preserved more readily in the privately funded homes than in the large state institutions.

With regard to mentally handicapped adults accommodated in State funded institutions, the writer has regularly observed conditions in one large establishment, the Midlands (Umgeni) Institute in Natal, and has noted numerous signs of improvement over the past two years.

At the instigation of the Social Workers, occupational therapy has increased, although it is still felt by the writer that this amenity needs extending to involve more patients. Contact has been established on a thrice-weekly basis with senior pupils at local high schools who visit the institution and interact with patients on a one-to-one basis, doing simple puzzles or playing board games.

One of the biggest innovations has been the inclusion of wheelchair-bound patients in excursions outside the institution. Such expeditions in the past have been rare, even for patients who are mobile. Recently the Social Workers have been able to arrange more frequent trips and to include a number of patients in wheelchairs.

In addition, improvements have been noted on the wards. Music is now being piped around the building and a number of patients appear to be enjoying this. General nursing students, during a training period at the institution, painted the walls of a ward for non-ambulatory patients with murals, in addition to making and hanging mobiles. This was something long advocated by the writer, but hitherto ignored.

Although these improvements are relatively slight it is felt that they are an encouraging sign. In the past the need to provide such amenities was never realised. It is hoped that this beginning will generate more innovations.



This chapter has traced the provision for children with mental handicap from the period of the early intelligence tests to the present day. Because such children will ultimately reach school-leaving age the availability of facilities for young adults with mental handicap has also been included.

It is almost eighty years since Dunston stressed the need to identify those whites regarded as feeble-minded. Today one of the main areas of concern is that so many blacks with mental handicap remain unidentified, particularly in the rural areas.

Dunston, in 1918, saw persons with mental handicap as moral degenerates who should be brought under control. In the 1990s the perceived reason for identification is to provide such persons with care and with appropriate education. The following chapter will discuss the amenities available for the non-European population.

Chapter XProvision for Mentally Handicapped Non-Europeans

Mention has already been made of the racial segregation of mentally retarded patients, with blacks being relegated to inferior accommodation as early as 1846. The use of black patients as a source of labour in institutions reserved for whites has also been recorded. By the first decade of the twentieth century this appears to have been a regular practice throughout the four territories.

It has been stated in previous chapters that a discussion of the political aspect of South Africa's racial policy is beyond the scope of this study and any mention of racial inequality has so far been brief. However, it is felt that this study would be presenting an incomplete depiction of the South African asylum facilities if the practical implications of racial inequality were not examined. Therefore this chapter will attempt to provide a comprehensive view of racially based policies within South African asylums from the mid-nineteenth century to the present day. The legislation appertaining to non-European groups; the standard of accommodation and amenities provided for them will be discussed.

Early statistics regarding patients of any race other than white have been found to be fragmented and sparse. Perhaps this in itself is indicative of the scant attention paid to the welfare of these patients prior to Union.

During the past three decades a number of public outcries have arisen over the standard of accommodation supplied for black patients in both public and privately run institutions.

These issues will be discussed and the resultant improvements, if any, will be considered.

a) Provision for Black and Coloured Lunatics in the Cape Colony during the Nineteenth Century

No reference to colour could be traced prior to the removal of the lunatics from the mainland to Robben Island in 1846. It was noted in Chapter III that Somerset Hospital, from its inception accommodated slaves, (who, by inference, were not white) as well as patients from other classes of society.

It was originally assumed by the present writer that these slaves would have been indigenous black South Africans, but further research indicated that this was not the case.

According to Armstrong (1979), although the first few slaves owned by the earliest Dutch settlers were indigenous, by the nineteenth century slaves in the Cape Colony were a racial mix. The earliest shipments had been from the West Coast of Africa, to be followed by imports from Java, Malaya, Timor, Burma and China. The British banned the importation of slaves in the Cape in 1807, shortly after their second occupation, but continued to allow slaves to be sold within the Colony. Slaves removed from visiting ships were "apprenticed" for a number of years to approved employers.

Burrows (1958) refers to Somerset hospital accommodating slaves and apprentices. It would appear that these were not

necessarily indigenous South Africans, but were likely to have been from the West Coast of Africa, from the East Indies or products of a racial mix.

When Somerset Hospital was taken over by the Burgher Senate in 1821 it was declared open "for the reception of Sick Persons of all descriptions, whether inhabitants of the Colony or Seamen, Slaves and Apprentices" Burrows (1958 p.112). It is not clear whether the term "inhabitants of the colony" refers to both European and non-European persons.

By 1842 a sliding scale of charges from three shillings down to one shilling and three pence, with free treatment for paupers, had been laid down by the Colonial Government. Burrows (1959) This would suggest that persons more affluent than the "Seaman, Slaves and Apprentices" were availing themselves of the facilities. It would appear unlikely that those patients paying the higher rates would be expected to share living space with the paupers or the former slaves. Thus a social stratification inside the hospital would seem feasible, although no reference is made to race.

As stated in Chapter IV, the lunatic patients, numbering thirty-seven in total, were transferred from Somerset Hospital to Robben Island in 1846. No record could be found to indicate the racial proportion of this group, nor of the additional thirteen transferees from other institutions who, according to de Villiers (1971), were also admitted to the island at approximately the same time.

Included in the report of the Commissioner in Mental Disorders (1918) is a short history of the lunatic asylum on

Robben Island, written by the Physician-Superintendent. He makes no mention of segregation of the races, merely stating that the sexes were separated, and that the accommodation allotted to the lunatics was far inferior to that of the lepers. De Villiers (1971) refers to the lunatics as either "European" or "Coloured persons", with no mention of black patients. It is noted that de Villiers is quoting from the account of a lunatic keeper newly arrived in the Cape from England where the interpretation of "Coloured person" differs from that in South Africa. To the English anyone of African ethnicity, and this includes West Indians, or anyone of mixed blood is "Coloured". It is therefore unclear whether the English generalisation may apply in this instance and that some of the so-called "coloured" patients were, indeed, black. Successive reports from the Commissions of Mental Hygiene merely categorise patients as European and non-European.

De Villiers (1971) states that by 1862 there were one hundred and sixty-six lunatics, race unspecified, on Robben Island. The earliest traceable statistics indicating the racial mix of patients was in 1913, when the number of patients had risen to four hundred and seventy-six. Of these only fifty-nine were European, with the remaining four hundred and seventeen being classified as non-Europeans. Report of the Commissioner in Mental Disorders (1918)

According to de Villiers (1971) certain forms of segregation took place among the lunatics from the inception of the asylum. As one would expect, the sexes were

segregated, somewhat unsuccessfully it would appear, because de Villiers (1971) cites the occurrence of several pregnancies among female patients. It may be, of course, that male members of staff were guilty of sexually abusing female patients.

The male lunatics were apparently segregated into two separate camps: "the asylum" and "lunatic square". It would appear that the non-violent, least retarded, male patients lived in "lunatic square". According to de Villiers (1971) these were predominantly, if not entirely, Europeans.

From the reports by various lunatic keepers, quoted in de Villiers (1971) it would appear that the more severely retarded male patients lived in the asylum. One might question whether it was coincidence that almost all the non-European patients on the island were included in this group. Reportedly these patients got less meat in their diet and had to sit on the ground to eat their meals as tables and chairs were not provided for them. They were also called upon to carry out the most strenuous tasks. If a boat landed at night it was these patients who were most likely to be called from their beds to unload both passengers and supplies, often returning to their beds soaked to the skin.

De Villiers (1971) makes no mention of former slaves among these non-Europeans, but if the present writer's conjecture is correct and slaves had been among the first transferees, then it would appear likely that, because of their status, they would automatically be included in any work force.

In the opinion of the present writer one of the most discriminatory acts against the non-European male patients was their form of dress. De Villiers (1971) reports that while the coloured patients were given only a white jacket and trousers to wear, the white patients were supplied with a check shirt and a waistcoat in addition to their jacket and trousers.

This is the only account of a racially discriminatory uniform being issued to lunatics that the writer has been able to trace anywhere in South Africa. It would have been of considerable interest to know if this was a common practice in the early asylums.

According to de Villiers (1971) no male patient on Robben Island was issued with either shoes or socks, which must have been a severe deprivation in the harsh Cape winters. It is not known whether this ruling applied to male patients alone, or whether female patients were also denied footwear.

This account is one of the few in the early records of provisions for lunatics in the Cape Colony where mention is made of gender. Not only does de Villiers (1971) report on the segregation of the sexes, but he describes the work of the male patients and also their allotted form of dress. Far less detail is available about the female patients.

It is now apparent that by the middle of the nineteenth century some racial disparity in asylums was in operation. Not only did such segregation apply to accommodation, but

apparently to the type of labour patients were expected to supply, and at least on Robben Island, to a different dress code. From that time onwards a pattern of racial discrimination is traceable.

b) Provision for Non-European Patients in the Asylums in South Africa - Late Nineteenth Century and Early Twentieth Century

As stated above, the earliest official records indicating classification into race groups was in 1913, when the total number of non-European patients on Robben island was stated to be four hundred and seventeen. Report of the Commissioner in Mental Disorders (1918)

Although it is not possible to ascertain how many of the original fifty patients on Robben Island were non-European, it is clear that their numbers had increased considerably between the inception of the asylum in 1846 and the first listed figures in 1913 shown in the previous paragraph.

However, this rise in the number of non-European patients is comparable with the increase in the number of European patients in Valkenburg over a similar period. Table I, Addendum to Chapter V, shows an increase from thirty-six European patients (all removed from Robben Island) in 1891, to five hundred and twenty European patients in Valkenburg by 1913.



Unfortunately when one compares population figures for both Europeans and non-Europeans in the Cape Province in 1913 the disparity between the perceived needs of institution placement for the two race groups shows a wide disparity:

|                                              |      |           |
|----------------------------------------------|------|-----------|
| Non-European patients on Robben Island 1913: |      | 417       |
| Non-European population in the Cape 1911:    |      | 1,982,588 |
| European patients in Valkenburg:             | 1913 | 520       |
| European population in the Cape:             | 1911 | 582,377   |

(No census was taken between 1911 and 1918)

It might be argued that by 1913 non-European patients were being accommodated in other asylums throughout the Cape Provinces and that the percentage of institutionalised patients was therefore higher than stated above. The writer would contend that this argument also applied to European patients, with the detailed figures supplied in the Addendum to Chapter V illustrating similar racial disparity.

The figures shown above would suggest that considerably less attention was paid to the identification and institutionalisation of non-Europeans.

It is suggested that unless the potential patient of either race group was violent, or had criminal tendencies it is likely that the initiative towards his or her committal would

normally originate with the family or close friends. The proportional imbalance in the figures shown above would suggest that a considerable number of the non-white population may have been suffering from a mild form of "lunacy", but that this would be tolerated by the immediate community and thus remain unidentified by the authorities. It is also suggested that these communities would rely more heavily on tribal remedies, rather than on Western doctors, thus such patients would remain largely undetected.

Attention has already been drawn to the similarity between the position of the so-called lunatic in pre-industrialised England in the early nineteenth century and in the pre-industrialised colonies in Southern Africa, some forty or fifty years later. It is further suggested that a similar parallel might be drawn between both these instances and the position of non-violent lunatics in the non-European races in South Africa as late as the beginning of the twentieth century.

A large proportion of the non-white population was living outside the urban areas. If they had employment their tasks were likely to be menial, requiring no great mental ability. As with the earlier examples, it is suggested that those with a relatively mild handicap would have been assimilated with relative ease into such a community. It is therefore likely that so-called lunacy among black South Africans went largely undetected until they moved into an urban environment, or unless they displayed violent or criminal tendencies.

The increase in the numbers of white patients, alleged to be insane, has already been discussed and attributed to the rising population in South Africa and to the migration from rural to urban areas where they were not easily assimilated.

It is suggested that the escalating numbers of non-European patients in Robben Island Asylum around the end of the nineteenth or the beginning of the twentieth century was also due to the migration of families into urban areas in search of employment and the subsequent identification of hitherto undetected cases of so-called insanity.

By 1894 the numbers of non-Europeans certified as insane (according to the prevailing practice) forced the authorities to consider the necessity of an additional asylum. Fort Beaufort Asylum, which was established in a derelict military barracks in 1894, is referred to in successive reports of the Commissioner in Mental Disorders as accommodating "Native, Coloured and Asiatic patients". This asylum was additional to the one on Robben Island, not a replacement. When one considers that the two institutions were approximately nine hundred kilometres apart their catchment areas would be unlikely to overlap.

#### c) Trends During the Early Twentieth Century

It has already been mentioned in Chapter IV that by 1916 a new trend was emerging, that of using non-European patients as a labour force in the asylums which accommodated only Europeans. Records have shown that this practice operated at

Valkenburg; Grahamstown; Bloemfontein and Pretoria, in fact, at every asylum occupied by European patients, with the possible exception of Pietermaritzburg. Town Hill accommodated European, Asian and African patients, each group in segregated buildings. The sole reference to non-European patients providing a work-force is in a short historical account of the hospital by the Physician-Superintendent, Dr.R.S.Black who wrote in 1918:

"In 1882 Dr.James Hyslop was appointed resident surgeon. He arrived in July and was so much disappointed with the primitive arrangements that he seriously considered the advisability of resigning and returning to Scotland....He found that none of the European patients did work of any kind and his first attempts to provide work were hampered by the refusal of the Government to provide tools. He managed to obtain, however, a few barrows and a few spades and set to work laying out the grounds and tree planting. In 1883 over 2,000 trees were planted and a start made with road making.

Cited in the report of the Commissioner in Mental Disorders  
1918.

The garden Hyslop designed at Town Hill was to become recognised as one of the finest in the area. No mention is made of whether he did obtain permission from the Government to employ white patients during its construction, neither is

it recorded whether the patients who were later employed on the road building project were all non-Europeans, although this would appear likely.

Although the differentiation between mental illness and mental handicap was only officially recognised in 1916 it would appear that medical authorities in the field of mental health had begun segregating white patients into unofficial categories of "curable" and "incurable" at a slightly earlier date. It has already been stated that Valkenburg, in 1890, accepted only those patients classed as "curable whites". It would appear that a somewhat different unofficial form of classification for black patients was being implemented by 1918. The demarcation here was between those considered incurable and those regarded as capable of providing a work force for the European hospitals. No trace could be found in records dating from that period of black patients being termed "curable".

A picture is emerging of black patients, considered unsuitable for inclusion in a work-force, being concentrated in the most inferior accommodation. Fort Beaufort Asylum had been condemned by a Parliamentary Select Committee in 1913 as defective, unsuitable and inadequate for the purpose of a mental hospital. Notwithstanding this fact, five years later the Commissioner in Mental Disorders declared that while it was very unsatisfactory for curable acute cases, it was "generally suitable for chronic native patients". (1918 p.23)

The report therefore recommended that chronic cases from other asylums should be moved into Fort Beaufort, leaving room for acute cases in other institutions. Thus Fort Beaufort not only continued to house patients already in residence, but was accepting the transfer of other chronic cases, all non-European, in spite of the fact that the premises had been condemned as defective by an investigating committee.

It is apparent that however low the status of the majority of European lunatics might have been, that of the non-Europeans was infinitely worse.

Similar conditions appear to have existed at the asylum in Port Alfred. The report from the Physician-Superintendent in 1918 describes the premises, former convict barracks, as being unsuitable for use as an asylum from its inception in 1888. Here again, the asylum accommodated only chronic cases, keeping full occupancy by taking transfer of suitable cases from other institutions.

The only difference between Fort Beaufort and Port Alfred would appear to be that by 1918 the latter accommodated sixty female European patients, all considered incurable, in addition to the two hundred and twenty native and coloured patients. Apparently the female European patients at Port Alfred had all been transferred from other institutions. The assumption is that they were rejected elsewhere, perhaps because of the severity of their handicap, and deposited at Port Alfred because nowhere else would accept them.

It would have been interesting to have learned why the only European patients at Port Alfred were female, when presumably the non-European patients were of both sexes, following the practice in other asylums. If, as the writer suggested in an earlier chapter, Port Alfred and Fort Beaufort were used as depositaries for incurable, low-grade mental defectives, one wonders what became of the male patients in this category. Unfortunately no further information was available.

One further point regarding the gender of patients should be made at this point. Although several references have been traced to non-European patients providing a work-force for European asylums, no mention could be found of the gender of these workers. Based on the description of them being used in building operations on several sites the present writer had assumed that the labour force would always be male. However the description of "quiet and hardworking natives and coloureds" transferred to Grahamstown could apply equally well to either sex. A work-force of female patients may possibly have been employed for domestic work inside the asylums.

The fact that there is so little mention of gender in the records on lunacy would suggest a high degree of de-personalisation on the part of those in authority. The patients were "lunatics", first and foremost. Any other detail was secondary.

By 1918 one thousand, one hundred and seventy-eight non-European patients were housed in former convict colonies or disused military barracks in the Cape Province. All these premises were described as derelict or totally unsuited for use as asylums.

Four hundred and twenty-five patients were on Robben Island; two hundred and twenty were in Port Alfred and Fort Beaufort housed five hundred and thirty-three. Black patients supplied the work force in the European hospitals at Grahamstown and Valkenburg.

In the Orange Free State the New Native Mental Hospital at Bloemfontein was completed in 1917. The following year there were three hundred and seventy-nine patients being accommodated in these premises. As stated earlier, black patients had supplied the labour during the construction of this building and continued to provide a work force during the building of the adjacent European hospital in 1918.

By 1908 six hundred and fifty-three non-European patients had been moved from temporary wood and iron structures into brick-built wards at the Pretoria Asylum. Records show that black patients here were used as a labour-force, clearing the ground for the new buildings which were to house European patients, and also on road works inside the grounds.

It would appear that the black patients in the Cape endured the most inferior accommodation. Although several asylums in the other provinces had by 1918 provided newly-built premises for black patients it has not been possible to ascertain the standard of accommodation which these offered.

#### d) Lack of Recognition of Feeble-mindedness in Non-Europeans

It has been stated in Chapter IX that while the attention of mental health authorities was focused on feeble-mindedness



among Europeans in the second and third decade of the twentieth century such a condition among other races was officially ignored.

In his report as Commissioner for Mental Hygiene (1928 to 1929 p.xi) Dunston stated that no special institutions had been established for the feeble-minded of any race other than European because:

" so limited a number of these has been notified or certified that there was no justification for establishing such institutions."

Whilst finally recognising, in the late 1920s, that a need existed for the coloured mental defectives, the report continues to deny the necessity of such facilities for other races:

"The need hardly exists in regard to the aborigines because - it would appear - of the results of the instinctive eugenic practices and customs amongst native tribes from olden times. Europeans have eliminated as far as was possible these eugenic practices for several generations, but in spite of this and the introduction of syphilis, alcoholic spirits and other supposedly disintegrating factors, the effects of the eugenical past have persisted. This is proved by the fact that in large towns and under conditions comparatively new and demoralizing to the native tribes, mental defectiveness, mental disorders, epilepsy and other conditions due to

mental degeneration are, in comparison with their population rare. The proportion of native patients in Mental hospitals to the total native population is 1 in 1,468.

Report of the Commissioner of Mental Hygiene  
1928/29 p. xii

Far from belatedly recognising the existence of feeble-mindedness among the black community and consequently attempting to rectify the errors of earlier negligence, Dunston continues to deny the existence of a problem. To reinforce this denial he presents evidence so incomprehensible that the various points must be individualised and analysed separately in order that they be understood.

Firstly, the eugenics allegedly practiced by "native tribes from olden times". Presumably this refers to the custom of allowing infants displaying obvious abnormalities at birth to die. It is debatable whether this practice could rightfully be termed eugenics. It is suggested that rather than being concerned with selective breeding, this practice eliminates those few individuals unlikely to survive in an environment that is frequently harsh.

However, Dunston is referring not to cases of severe mental or physical handicap, but to feeble-mindedness. In his 1918 report Dunston had stated that, "Feeble-mindedness in children is not easy to diagnose ..." (p.16) and "To the majority the feeble-minded are not obviously defective..."(p.12), yet he is now suggesting the natives

identified feeble-mindedness among members of their own race and eradicated those exhibiting symptoms. If members of the medical profession found feeble-mindedness so difficult to diagnose one may wonder how the natives were able to identify the condition and eliminate the victims. Whereas Dunston's argument regarding eugenics may have applied to the severely handicapped it is argued that this is not applicable to the feeble-minded.

The second point appears to be an anomaly. Dunston asserts that in spite of Europeans eliminating "as far as possible these eugenic practices... the effects of the eugenical past have persisted."

It is suggested that if the Europeans had achieved any measure of success in their aim of eliminating the practice of eugenics then a certain proportion of those previously condemned to die would have now survived. One might ask where they were.

Finally, "the introduction of syphilis, alcoholic spirits and other supposedly disintegrating factors", which in other races lead to mental degeneration apparently leave the native population unscathed. One wonders what basis Dunston, a doctor of medicine, had for making this assertion. It may be that his practice did not extend to non-European patients.

It is suggested that these purported reasons for the absence of feeble-mindedness among the black population were merely a reinforcement of the policy of denial. To have acknowledged

this problem might have inferred an obligation to provide amenities for those concerned. The comments by Dunston were made during 1928/29 when the country was still in the throes of the Depression. Facilities for the feeble-minded among the white community remained grossly inadequate, and it was the policy of the South African government to give priority to those of the white race, even to the detriment of all other races.

In addition, as suggested earlier, there was the perceived need of white South Africans to justify racial dominance by upholding a belief that the intelligence of the white was superior to that of the black.

With the official recognition of feeble-mindedness as a category of mental retardation in 1916 a new problem was created. If the intelligence of ordinary blacks was regarded as being below that of the average whites, one had to question where this placed them in relation to the feeble-minded whites. As feeble-mindedness was classified as the highest category of mental sub-normality, one may assume that all blacks would be regarded as being on an intellectual par with feeble-minded whites. To have acknowledged a category of feeble-mindedness among blacks based on the classification used for whites, would, therefore, imply that their normal intelligence level could be equated with that of the whites. This was a proposition not acceptable to the governing white supremacists.

This chapter will later contain a section on the comparison of various racial groups in South African intelligence tests, as conducted by Fick during the late 1920s.

It will be noted from Dunston's 1928-1929 report that the need for institutions for the feeble-minded among the coloured population was being realised by that date. One wonders why such a need was acknowledged for this particular race group. It may have been a question of visibility. If the coloured communities lived closer to the urban areas then the medical profession could hardly deny their existence. Whatever the reason, the coloureds were the first non-European group in which feeble-mindedness was acknowledged.

**e) Perceived Attitudes of the Indian Community towards the  
Mentally Handicapped**

As far back as 1928-1929 Dunston wrote:

"With regard to the Asiatics, we know little or nothing. Though in the Union of South Africa there is a population of 189,000 of these, we have only 145 in our mental institutions, i.e. a proportion of 1 to 1,234. It would appear that amongst the Asiatics either the problem is a very small one or they deal with it as a community, with little reference to the Mental Disorders Act or any form of Government control or help."

There can be little doubt that Dunston was using whites as a yardstick. Now, by convention, we recognise that mental retardation occurs in the same proportion across the races. It is suggested that a wrongful assumption by Dunston was due to a lack of identification of the problem by the mental health authorities.

Dunston also asserts strong community involvement among the Asiatics in the 1920s. Personal research at the H.S.Ebrahim Training Centre, Pietermaritzburg, during the 1980s and observations and interviews at the S.Dass School, Phoenix, during the 1990s would lead the present writer to affirm that this statement is true at the present time. Lack of evidence precludes her from concurring with Dunston over the position in the 1920s.

Seventy years after Dunston's comment, the Indian fraternity offers immense financial support and community involvement to the schools for the mentally retarded Indian children. Frequent and most generous donations are made by local businessmen and in addition, medical practitioners, including orthopaedic specialists; paediatricians; E.N.T.specialists and general practitioners frequently give their services free to many of the Indian special schools. Many supermarkets also supply food for school meals on a regular basis.

Regarding the assertion by Dunston that the problem of feeble-mindedness among the Indians was small, it is suggested that this was rather a question of visibility. Research by the writer in the 1980s and interviews conducted during the

present study suggest that the African and the Indian families tended, until very recently, to shield their mentally defective children from public view.

Because the earlier research, conducted as part of an M.A. degree, (Shirley, 1984) has relevance to the perception of the Indian community with regard to their mentally retarded offspring, some details of this are described below.

During 1984-85 the writer did research work one day a week with a class of pupils from the H.S.Ebrahim Training Centre for the Mentally Handicapped in Pietermaritzburg. This work revealed that even in the 1980s the Indian community appeared, in general, to be highly protective of their retarded children to an extent which is unusual among European communities.

This attitude seemed to be associated with three factors, ascertained from personal observation, interviews with parents and discussions with teachers.

Predominant among these causes was the assumption that the child was physically sick and required considerable periods of rest. This applied equally to children with or without additional physical handicaps. The children were collected outside their homes by the Centre's mini-bus and deposited at the school door. They spent the greater part of the school day sitting in classrooms. It was observed that few indulged in any form of physical activity during the break

period, most of them simply stood or sat in one place. A few periods of sport were scheduled during the week, but these mostly consisted of football for the boys. The girls' occupations were almost exclusively sedentary.

In the early afternoon the children were delivered to their homes by mini-bus, whereupon most parents insisted on a period of rest until the evening meal. This was invariably followed by an evening spent watching television, before bedtime at around 8.00 p.m., regardless of the fact that many of these children were in their mid or late teens.

Secondly, there was a the fear the child would get physically hurt if allowed to play with ordinary children, either indoors or out of doors, or that he would be taunted by his normal peers.

Lastly, there was the sense of shame experienced by many parents at having produced a retarded child. They wished to keep the child hidden within the extended family. Thus the retarded child was frequently excluded from family outings, even to church or temple, being left at home in the care of either an elderly female relative or a servant.

It was interesting to note that in the case of retarded pubescent girls, parents and female relatives frequently conspired to repress the burgeoning signs of physical development by dressing the girl as though she was still a young child. It is suggested that the reason for this behaviour may be as a form of protection for the girl against sexual advances by males.



f) Comparison of Various Racial Groups in South African  
Intelligence Testing

Dunston's (1928-1929) references to the alleged inferior intelligence of non-European race groups have already been noted in this study.

The present section will discuss a series of intelligence tests conducted by Dr. M.L.Fick, the Psychologist to the Department of the Interior in the late 1920s, and his reported findings.

The Social and Industrial Review (1924-1935 p.139-143) published part of a paper delivered by Fick to the Johannesburg Society of Mental Hygiene in which he described the uses and applications of intelligence tests in dealing with sub-normal and defective children. Outlining the differences between group testing and individual testing, Fick states that the group test is used as a sifting process, adding that the child who does badly on the group test should be given the benefit of the doubt and be retested by means of an individual test.

The children referred in this paper were all European, and it would appear that the "sifting process" applied only to them. In a later article Fick refers to the testing of "poor whites" and "natives" and it would appear that in both these instances group testing was the only form used. If one uses Fick's criteria of a "child who does badly on the group test"

as being the one who "should be given the benefit of the doubt and retested", this would seem to apply to the majority of the poor white and native children, yet Fick makes no mention of any individual tests being conducted here.

In view of the alleged correlation between poor whiteism and feeble-mindedness discussed in a earlier chapter, it is interesting to note that Fick appears to have always tested poor white children separately from other European children. One wonders if the prejudice against the poor whites, evidenced in Dunston's reports (1918-1926), was so strong among the mental health fraternity that Fick was anticipating meaningfully lower scores from the poor white children, even before the testing process had begun.

Two extracts from a paper Fick delivered to the British Association for the Advancement of Science in 1929 were also published in the Social and Industrial Review: 1924 - 1935. The first extract (p.701) outlines the intelligence testing carried out for the Department of Mental Hygiene as previously mentioned, and states that this had now been standardised on more than 10,000 European children between the ages of 10-14 inclusive, in areas selected as representative of the Union.

Fick states that his European group "representative of the Union" would be used to form the basis of comparing different groups. This was to be called "the standard group", and represented:

"an average of the European population including superior, medium and inferior areas. The superior groups of the Union would be markedly higher than this standard." (1929 p.102)

Referring to the tests on poor white and native children, in the second extract from his paper, Fick (1929) explains that these tests measured primarily the type of intelligence required to do the work of the ordinary classroom, which demands the manipulation of symbols and representations of things rather than the things themselves. Fick does admit that one is forced to recognise in practice that some children who do badly in this type of test prove highly successful in vocational work. (August 1929)

The stated purpose of all these tests, according to Fick, (1929 p.701) was the comparison of various racial groups. Because of its non-linguistic responses and directions, the Group Test (the Army Beta Test) was considered eminently suitable for comparisons in a country where more than one language is spoken. Fick adds:

"Investigators who have had to cope with the language factor in comparing groups speaking different languages know how futile is the naive suggestion that each individual be tested in his own language."

It is of interest to note that the manual for the present day Standardised Intelligence Test, SSAIS-R, states that tests should contain as few biased items as possible in respect of language/gender/socio-economic environment, and that the test should aim to:

"...obtain a differential picture of certain cognitive abilities. Firstly the level of general intelligence is determined, for instance to predict scholastic achievement. Secondly relative strengths are evaluated to obtain diagnostic and prognostic information."

It will be noted that the only test results published by Fick refer to those of the coloured, Indian and native children. The results of the testing of the poor white children are confined to generalised comments about the inability of this group to complete primary school education, and the futility of their continued attendance at school, once their condition has been diagnosed.

#### Coloured Children

4,721 children from large urban area, Western Cape  
 817 children from towns in same province  
 329 children from surrounding districts

**Results - Children reaching or exceeding  
Standard Group median:**

**Urban area average 12.5%**

**Town area average 6.9%**

**District area average .8%**

These represent the percentage of children whose intellectual ability as measured on this test lay in the same range as 50% of the standard group.

**Indian Children**

Children tested from two schools in a large urban area, Natal, and one school outside this area. No figures for individual schools, only 762 in total.

**Results - Children reaching or exceeding  
Standard Group median:**

**No details given for individual schools  
Stated medians found to be well below  
Standard Group, average 6.4%**

**Native (Zulu) Children**

Apparently the only African children Fick (1929 p.703) tested were Zulu children in Natal. The group tested is described as being from:

"... two schools in a large urban area in Natal and children some twenty miles from this area. One of the schools in the urban area was rated superior and the other inferior by the education authorities."

No figures for individual schools were given, and only 293 children tested in total.

Results - Children reaching or exceeding  
 Standard Group Median: 1.2%  
 No details for individual schools.

#### Conclusions Arising from the Fick Reports

The numbers of children tested in each race group would appear to be disproportionate to the percentage of that particular group in the general population:

|                          |                     |
|--------------------------|---------------------|
| European children tested | 10,000              |
| Coloured children tested | 5,867 (W.Cape only) |
| Indian children tested   | 762 (Natal only)    |
| Black children tested    | 293 (Zulu only)     |

Difficulty was experienced in obtaining population figures, based on race for the 1920s. As previously stated, the census for whites was taken every five years, while a general census of all race groups was taken only at ten yearly intervals.

This fact alone is indicative of the dominant status of the Europeans in South Africa. The figures quoted below were judged to be the most appropriate for the 1920s.

Racial Proportion of General Population

|      | <u>Whites</u> | <u>Coloured</u> | <u>Asian</u> | <u>Black</u> |
|------|---------------|-----------------|--------------|--------------|
| 1921 | 22%           | 7.9%            | 2.4%         | 67.8%        |

(Results of the Population Census 1921)

While accepting that the above figures came from an official source, it is suggested that their accuracy may be questionable. The ratio of native Africans to Europeans would appear to be disproportionately low. It is suggested that this may be due to the omission of many Africans in remote rural areas in the census.

Although the accuracy of the figures may be in some doubt, it is apparent that the black population greatly outnumbered the whites, yet Fick tested only 293 black children against 10,000 white children.

More important than the disproportionate number of children tested in each race group, however, is the fact that the samples lack full representation. Such a grouping would today be considered unacceptable. The Standard Intelligence Test SSAIS-R specifies that intra-grouping, not cross-grouping, be used.

It is further suggested that the papers Fick (1929) wrote on the comparison of various racial groups undergoing the South African intelligence tests show bias. In his paper on the testing of ordinary European children and the poor white children Fick (1927) emphasises such factors as malnutrition, unfavourable home environment and frequent absence from school as being contributory factors in low performance in the tests. Such factors appear to be unrecognised during the testing of the other race groups, although one would imagine their prevalence would be greater.

Fick (1929 p.701) states that the group tests were non-linguistic in responses and directions, thus:

"...it is eminently suited for comparisons in a country where more than one language is spoken."

The writer would argue that non-European children would still have been at a disadvantage. Presumably the examiner would address them initially, either using English, with which they were probably unfamiliar, or with the services of an interpreter, a method which is likely to have appeared strange to the children. Perhaps, in the 1920s, many black children were even unaccustomed to white faces in close proximity.

It is suggested that Fick anticipated that the testing would result in lower scores for non-European groups, particularly the black children and that he chose to ignore the contributory factors mentioned above. It is also



suggested that the unfamiliarity of the black children with "the manipulation of symbols and the representations of things rather than the things themselves" which Fick describes was not sufficiently taken into account when the results were quantified.

Thus Fick achieved the results he expected and was able to conclude that:

" Such a rating of the native (Zulu) school children intelligence appears astoundingly low. Unfortunately, such a finding appears to be corroborated by the uncontradicted statement which appeared recently in a speech published in the Cape Times of the 20th. February 1929, namely, that only 13 natives in 20,000 attained Standard VII."

Fick (1929 p.703)

If the black children were indeed so mentally inferior to children of other races, particularly to white children, one might question why the state neglected to provide special educational facilities for them. The most likely answer would appear to be that blacks were seen as subservient to whites. Economically and politically it suited the premise of white supremacy to keep the blacks in this position. Until the 1990s the education of all black children was grossly inferior to that of their white counterparts. It is therefore hardly surprising that the plight of mentally handicapped black children in need of special education was ignored for so long.

Dr.C.T.Loram (1929 p.704), an eminent authority on native education in the early part of the twentieth century, questions whether the intelligence tests are fair to native children, particularly as "they measure chiefly that type of intelligence required to do the school work of the ordinary classroom." While asserting that "there is no doubt that the native does not show up well, according to educational authorities", Loram (1929 p.704) suggests that "possibly the native child may have a different type of intelligence."

In his conclusion Loram (1929 p.704) states that while the native is considerably lower in intelligence than the European children, the "inferior" is not so great as has been commonly believed. It is his stated belief that the test items are too arbitrary and the time allotted to the tests too variable for the results to be meaningful.

It is noted that while Loram refutes, to a some extent, the results of the testing by Fick, he continues to regard the native children as having considerably lower intelligence than European children. If this is the view expressed by Loram, regarded during the 1920s as an authority on native education, then it is perhaps understandable that such a concept should permeate throughout South African society, particularly as it was in the interest of the Europeans to foster such a perception.

Whether one favours the findings of Fick or Loram, the undeniable fact is that considerable numbers of non-European children appear to have been identified in the 1920s as being

in need of special education. The preceeding chapter of this study showed how long it was to be before those needs were met.

The following section will examine another field, the quality of the residential accommodation available to non-Europeans, both children and adults, who were mentally handicapped. Although all institutions theoretically became multi-racial in the 1990s, it would appear that at the time of writing, 1996, the number of transfers has been small. It is noticeable that almost all movement has been from non-European institutions into those hospitals formerly designated for whites only. This section will endeavour to discover the differences, if any, in accommodation provided for different race groups.

g) Residential Accommodation for Mentally Handicapped  
Non-European Adults during the Second Half of the Twentieth  
Century.

As stated earlier in this chapter, by the second decade of the twentieth century non-Europeans certified as insane were housed in segregated quarters in six asylums throughout the Union, and provided a labour force at two other asylums designated exclusively for white patients.

The removal of the last lunatics, approximately 435 black patients, from Robben Island during the 1920s, exacerbated the overcrowding of accommodation for black patients elsewhere. A

statement made in 1937 by a member of the Council of Mental Health should be noted at this point. While appealing for more accommodation for black mentally handicapped persons the spokesman remarked that:

"...the Council believed that the "comparative luxury" of Alexandra (an institution for feeble-minded whites in Cape Town) was wasted on mentally handicapped persons since they were not able to "appreciate the comforts." (National Council for Mental Health Report 1937 p.3)

If such a statement was indicative of the attitude of the National Council of Mental Health in 1937, one can hardly be surprised if society in general was indifferent to the needs of mentally handicapped persons.

All the brochures supplied to the present writer by mental hospitals indicate that between the mid-1920s and the mid-1940s extensive plans for major renovations and extensions were mooted. However, it is apparent from these documents that such work was severely curtailed throughout this period, firstly because of Depression, then by advent of World War II immediately afterwards.

While it is appreciated that the wartime strictures on building programmes continued to operate for some years following the end of the war in 1945, it is difficult to understand why the shortage of accommodation for black patients had reached crisis point by the beginning of the

1960s. A similar situation does not appear to have occurred in the sector for white patients. Perhaps one should presume that when the planned extensions were accomplished during the 1950s these were provided for white patients only.

Whatever the reason, by 1963 state institutions could no longer handle the number of black patients, both chronic psychiatric and mentally handicapped, judged to be in need of institutional care. In 1963 the Department of Health invited tenders for the provision of "simplified " accommodation for these patients, many of whom were severely handicapped.

The tender was awarded to a private company, Smith, Mitchell and Company, a firm of chartered accountants acting on behalf of certain companies in the pharmaceutical field. The accommodation was in vacated mining compounds on the Witwatersrand and the original number of patients involved was approximately 700. Vitus (1987) According to Vitus, certain Members of the Cabinet were at that time serving on the boards of directors of some of the pharmaceutical companies involved, which placed the Department of Health in an awkward position. This does not appear to have stopped the transaction taking place, indeed the numbers of patients accommodated in conjunction with Smith, Mitchell and Company over the next twelve years escalated. Reports vary as to the exact figure. The Sunday Times (27th. April 1975) declares the number of patients living in these compounds was somewhere between 5,000 and 8,000 by 1975. Vitus (1987) states that by the same date the figure was 10,000 patients, mostly black, The Minister

of Health, answering a question in the House gave the total as 11,245 patients living in 13 institutions managed by Smith, Mitchell and Company in 1975. Hansard (2nd.May 1975)

On the 27th. April 1975 the South African Sunday Times published an expose of conditions in the Smith, Mitchell institutions. They were described as "human warehouses, rendering only custodial care", where patients slept on thin mats on a concrete floor and where costs were cut to the minimum. According to the reporter there were an average of thirty qualified staff to 1,200 patients, many of whom were severely or profoundly handicapped, with no qualified psychiatrists in residence at any of the facilities.

The Times accused the government of cloaking the scheme in an air of secrecy and shortly thereafter questions began to be raised in Parliament about patients in non-governmental institutions.

On 2nd. May 1975 Dr.A.L.Boraine asked the Minister of Health for figures appertaining to the non-governmental institutions and was provided with these details:

Patient Numbers in Institutions Administered by  
Smith, Mitchell and Company as at 31st. December 1974

|          |       |
|----------|-------|
| White    | 521   |
| Coloured | 336   |
| Black    | 7,062 |
| Asiatic  | 254   |

(Hansard 2nd.May 1975)

On 18th. June 1975 Mr. H. E. J. Van Rensburg asked for more detailed information regarding: rehabilitation facilities; number of trained staff; size of space allocated per patient; provision of bedding and furniture, and the programme of inspection which was carried out at the privately funded institutions. (Hansard 18th. June 1975)

Either by accident or design, Van Rensburg's question was tabled immediately prior to the prorogation of Parliament. Consequently it never received a reply.

From 1975 to 1978 no record of further questions on this subject in Parliament could be traced.

On the 1st. March 1978 Van Rensburg asked the Minister of Health whether any plans were being made for the building of new mental institutions. The Minister replied that a number of new institutions were envisaged for the near future. (Hansard 1st. March 1978)

One year later, on the 23rd. February 1979, Van Rensburg asked what progress had been made in the establishment of the new institutions for mental patients referred to by him on the 1st. March 1978. The Minister replied as follows:

- a) the first phase of the Mitchells Plain Hospital was in sketchplan stage, and that the tender date was set for 1979/80.

b) the Verulum Hospital was in the planning stage, with a tender date of 1983.

c) included in the programme of major works for 1983/4 were proposed institutions at:

i) Soweto; ii) Mamelodi; iii) Vereeniging

iv) Daveyton; v) Secunda

(Hansard 23rd. February 1979)

The following year, on the 27th. February 1980, Van Rensburg asked the Minister whether his Department intended to phase out institutions for mental patients which were run by private organisations; if so, what progress had been made in doing so; if not, why not? The Minister stated additional funds had been approved by the Treasury for the 1980/81 financial year to expedite the erection of 540 beds in the Eastern Cape area. Also that the following projects were now included in the 1979/84 building programme of the Department of Public Works:

i) Soweto: Erection of an 100 bed hospital for Blacks.  
Estimated tender date June 1984.

ii) Pretoria: Erection of 600 additional beds for Blacks  
(Westfort Hospital)  
Estimated tender date March 1983



iii) Queenstown: Erection of 90 additional beds for  
Blacks (Komani  
Hospital).

Estimated tender date July 1982

iv) Bloemfontein: Erection of a 700 bed hospital for  
Blacks

Estimated tender date September 1984

v) Port Elizabeth: Erection of a 1,080 bed hospital for  
Blacks

Estimated tender date September 1984

(Hansard 27th. February 1980)

It has not been possible to ascertain how much of this proposed building work has taken place during the past fifteen years. It appears that at least one of the projected plans, that for the institution at Veralum, has never materialised. It seems likely, although unconfirmed, that this is also true of a number of similar projects for the black townships.

Whatever the increase in accommodation, it appears to have done little to alleviate the shortage of accommodation for black patients. Despite the assurances by the Minister of Health fifteen years ago thousands of mentally handicapped and mentally ill black patients continue to be housed in accommodation provided by the private sector, and according to a recent government report, conditions show little improvement.

This report will be the subject of discussion in the following chapter.

In England in 1974 Sir Keith Joseph, the Secretary of State for Social Services, said,

"There is no doubt that the occasional scandal does an enormous amount for a social service."

Martin (1984)

This was following a scandal involving the alleged ill-treatment of geriatric patients at two mental hospitals in the U.K.

Joseph's statement may be true of England, but it fails to apply in South Africa. Little or no change appears to have followed the exposure of conditions by the Sunday Times in 1975. It remains to be seen whether the recommendations of the 1995 report mentioned above have any better effect.

At the beginning of this study the situation at St. Anne's Hospital in Umlazi, Natal, was mentioned. Dr. Mokoape, the Medical Superintendent, described the scene as "a medieval horror chamber". In July 1994 it had been alleged in The Daily News that eighty severely disabled and mentally handicapped black children were living at St. Anne's in deplorable conditions.

By March 1995 it appears that nothing had changed. Describing the situation Mokoape states:

"Of course it's a racial issue - had they not been black, there would have been an immediate outcry."

The Daily News, March 31st.1995

Throughout this chapter it has been apparent that there has been, from the beginning of insitutionalisation in South Africa, a wide discrepancy between amenities provided for the whites and those provided for the other races, particularly the blacks. A subsequent chapter will discuss the changes which are perceived to be necessary before there is parity between the race groups, and those changes which may have already have taken place. At the present time one can still say that to be mentally handicapped is to be disadvantaged; to be black and mentally handicapped in South Africa is to be doubly disadvantaged.

## Chapter XI

### Emerging Trends regarding Mental Retardation in Governmental Reports in Post-Apartheid South Africa

It has been suggested earlier that perceptions of the mentally handicapped are often revealed in the legal provision made for their welfare at governmental level. Previous chapters have traced the highly questionable certification process of the early nineteenth century by which the so-called lunatics in the Cape Colony were confined to Somerset Hospital and later transferred to Robben Island.

Commencing with the Acts promulgated in the mid-nineteenth century, Governmental reports and legislative Acts appertaining to lunacy have been discussed. It has been noted that prior to the introduction of apartheid in 1948 the mental health laws did not specifically mention race, even though racism was evident, but from 1960 onwards such legislation unequivocally separated persons with mental handicap into racial categories.

For the next three decades, the 1960s to the 1990s, all legislation relating to individuals with mental handicap applied specifically to one particular race group. The present chapter will consider the reports of various committees implemented during the period of the Government of National Unity, when for the first time, the affairs of all race groups are being integrated. The chapter will close with a discussion of the implications of the new Constitution for the persons with mental handicap.

a) The Purpose of Chapter XI

Abraham Lincoln is purported to have said, "You need to know where you are before you can decide where you are going." Fargo, Laine & Apffel, (1976)

The purpose of this present chapter is to establish where South Africa is in terms of legal provision for persons with mental handicap in the mid-1990s and to discuss the recommendations made in the various reports. This chapter will discuss the extent to which it is possible to detect some indication of what provisions are likely to be made for the mentally handicapped in the immediate future.

Socially and politically South Africa has undergone a metamorphosis during the first half of the 1990s. The new Constitution was adopted by the Constitutional Assembly on 8th. May 1996, but opposition parties called for the ratification of certain clauses and the amended Constitution was finally submitted to the Constitutional Court for approval on October 11th.1996. Chapter XI will discuss the relevance of this document to persons with mental handicap.

Also under discussion will be the following documents, in chronological order:

Report of the Committee to Review the Organisation,  
Governance and Funding of Schools 31st. August 1995

Report of the Mental Health and Substance Abuse Committee  
November 1995

Government Gazette No.17038: Integrated National  
Disability Strategy of the Government of National Unity,  
14th.March 1996

Government Gazette No. 17136: South African Schools Bill  
24th. April 1996

b) Report of the Committee to Review the Organisation,  
Governance and Funding of Schools 1995

This report covered "a national framework of school  
organisation and ownership, and the norms and standards on  
school governance..." (p.viii)

Given a brief to cover such a wide spectrum one must expect  
that the findings relating to schools for children with  
special needs could receive only small mention. However, the  
report states that an investigation into the requirements of  
learners with special educational needs (LSEN) is to be  
implemented and consequently their own points in relation to  
such education are brief. The present writer would therefore  
suggest that this document be regarded as merely an interim  
report in the present context.

The issues raised in the report are stated below:

The main concern of the committee appears to be the  
elimination of the racial inequalities which occurred in  
special education during the apartheid era. While stressing

the current inadequacy of provision for African children with special needs, the report points out that a large proportion of these children are receiving no education at all.

Furthermore the report states that many mildly or moderately mentally handicapped African children are mainstreamed by default rather than by intent. This allegedly occurs especially in rural areas where such children are found in large classes. Rarely is there any support system and frequently their needs for special education pass unnoticed.

According to the report the majority of African children identified as being in need of special education, but who are not receiving appropriate schooling, are from impoverished families. Therefore the committee makes the following recommendation:

"Parents of learners with special educational needs should not have to shoulder the expense of their children's education unaided. The same system of obligatory fees on a sliding scale and with zero-rating for the poor that is recommended for regular schools, should be applied in the case of special needs education." (p.81)

It appears that two separate concerns are being raised here:

- a) The need to provide special education for black children at present unable to obtain access to this facility.

- b) The need for such specialised education to be subject to the same obligatory system of fees as ordinary education.

At the present time, particularly in rural areas, it is suggested that special education facilities are unavailable, therefore the question of fees is irrelevant. Only if a parent in these areas was willing to send a child as a boarder to a special school in an urban area would the question of fees be appropriate. There is also the question of availability of residential places in urban special schools.

The recommendations of the committee with regard to children with special needs are commendable. Few would argue against the urgency of seeking out and identifying these children, particularly in the rural areas. Nor would most people question their right to be provided with appropriate education, free of charge if necessary. Unfortunately the costs for such an enterprise will be heavy, firstly in the employment of suitably qualified staff to undertake the identification process, and secondly in the provision of special facilities and trained teachers. It is suggested that in the economic climate prevailing in South Africa in general and in education in particular, such needs are unlikely to be met.

The findings of the investigative committee on learners with special educational needs, to which the above report refers, are awaited with interest. One can only hope that they will concur with those of the 1995 committee and that sufficient pressure can be applied to the government for adequate funding for this undertaking.



c) Report of the Mental Health and Substance Abuse Committee  
1995

It was the brief of this Committee to report on human rights violations and allegations in psychiatric hospitals nationwide. It is ironic that in the mid-1990s large numbers of mentally retarded persons were found to be living in institutions which appear to be little better than Somerset Hospital one hundred and fifty years ago. Furthermore, it will be seen that the Committee uncovered numerous cases of alleged violence towards patients; drug abuse by staff and patients, and instances of sexual abuse of female patients.

In February 1995, as a result of numerous allegations by members of the staff at psychiatric hospitals and also by concerned members of the public, this investigative committee was formed by the Minister of Health in the Government of National Unity, Dr.N.C.Dlamini-Zuma.

The terms of reference of the committee were to investigate and report on any malpractices or violation of human rights in psychiatric hospitals and to make recommendations to enhance the standard of care in such hospitals. The Committee was to be known as the Mental Health and Substance Abuse Committee, and was to be under the chairmanship of Prof.T.B.Pretorius. The modus operandi was to be six working groups, each consisting of two persons, to identify psychiatric institutions, then to visit and conduct on-site inspections and interviews based on a structured questionnaire. Finally the committee was to compile a report.

This section will look at the committee's report in some detail, but before doing so a number of points should be made.

Firstly, the report relates solely to psychiatric hospitals. Hospital staff report that where a hospital accommodates mentally handicapped patients and psychiatric patients in separate wards only the latter wards were inspected. In seventeen of the thirty-two hospitals visited mentally handicapped and psychiatric patients were integrated in the wards and could not be separated for the purpose of the report. Because this study is concerned with the mentally handicapped, only these institutions, i.e. those having integrated wards, will be discussed.

It would have been useful to learn why the brief of the committee did not include institutions for mentally retarded patients. Unfortunately no such information was obtainable. It will have been noted that the committee was formed as a result of allegations of drug abuse and violation of human rights. If such malpractices occur in the psychiatric wards, they seem likely to have arisen in the wards for mentally handicapped patients in the same hospital. It will be shown in this study that where mentally handicapped patients were integrated with psychiatric patients cases of drug abuse and violation of human rights were alleged against both category of patient.

The vulnerability of the patients with mental handicap is particularly disturbing when one realises that the 1995 committee was implemented following allegations made by staff

at psychiatric hospitals, who bore personal witness to cases of abuse of patients. No similar charges appear to have been made by staff at hospitals for the mentally retarded. One assumes that should similar allegations have been made then the brief given to the committee would have included both types of institution. One may conjecture that either such cases went unreported, or were too few to warrant inclusion in the investigation. If patients with mental handicap were omitted from the investigation due to the absence of complaints, the present writer would suggest the following reasons for this:

- a) Many of the mentally handicapped lack the articulation to verbalise their complaints to the proper authorities.
- b) They do not know to whom their complaints against staff should be addressed.
- c) Complaints to visiting families may be dismissed as figments of the patient's imagination and consequently are taken no further.
- d) Parents may not recourse to the correct authority through fear of retribution to the patient, or of having the patients labelled a troublemaker.
- e) Patients may have withheld complaints through fear of retribution.

The present writer feels strongly that a similar committee should be set up to investigate and report on conditions in hospitals for the mentally handicapped.

Secondly, in their report the committee states that they visited one or two institutions in a day. In a telephonic conversation with the writer, a spokeswoman for the National Council of Mental Health in Pretoria, asserted that there had been many complaints from members of staff at the institutions regarding these visits. Staff expressed concern that the visits were too short to allow the committee to make a meaningful assessment. The reported duration of the visits was between thirty and sixty minutes.

If the visits were as short as many staff allege, this brings to mind the accounts of cursory inspections of lunatic asylums in early nineteenth century England, when many cases of ill-treatment, cruelty and neglect went unnoticed because of ineffectual visitations. Scull (1989)

Section 5.4.5. of the report states,

"...Previous inspections have been mere charades as is evident from the disastrous situation which now exists in hospitals, but to which no specific attention has been drawn before."

One must hope that the inspections of the 1995 committee, although apparently somewhat brief, were more thorough than those referred to above.

Thirdly, it is suggested that a more realistic picture of conditions in the institutions would have been obtained had the committee not notified staff in advance of their impending visit. The report states that surprise visits would have been difficult because the committee needed completed forms to familiarise themselves with the nature and size of the institution. The present writer suggests that this reasoning is unacceptable. It would have been expected that mental health authorities ought to have all the necessary statistics and one wonders why these were not accessed.

The advantage the committee may have gained by affecting an unannounced visit is borne out by at least one instance, mentioned in the report, where the committee discovered that new clothes and bed-linen were issued immediately prior to the visit and promptly removed afterwards.

In the beginning of the report it was stated that the intention of the committee was to place the hospitals under one of three headings at the culmination of their inspections. The headings were stated to be: "Appalling"; "Broadly Acceptable", and "Between the Two". It may be that this system was used in some preliminary notes, but in the final report there is no form of grading for the institutions.

Listed below are the observations, slightly abbreviated, of the committee on individual institutions, followed by some of their generalised findings and their recommendations. The comments of the present writer are made separately. It will

be noted that reports on some hospitals are comparatively detailed while others are exceptionally brief. One presumes the style and length of these written observations was dependant on individual teams.

The institutions are listed according to province:

Eastern Cape

Fort England      60 mentally retarded patients integrated in a modern 470 bed psychiatric hospital. Patients black and white. Food poor; physical restraint in regular use; drug abuse rife among staff. Allegedly patients sometimes put in solitary confinement and drugged so severely they could hardly move. This is done as a punishment.

Tower

(formerly Fort Beaufort)

60 mentally retarded patients integrated into 600 bed psychiatric hospital. Patients all black. Although now modern, there was little hot water and no privacy for patients. Clothes, bed-linen, food satisfactory. Alleged dagga abuse among patients.

Komani,

Unspecified number of mentally retarded patients, integrated with psychiatric patients in this 800 bed hospital. Buildings partly old, partly new. Patients black and white.

Allegedly white patients are housed in the modern buildings which are clean and better equipped. Old buildings appalling; bedding in bad condition; no recreational facilities; gross understaffing and poor administration.

Elizabeth Donkin, 4 mentally retarded patients in this 163 bed psychiatric hospital. Patients black and white. Food poor and inadequate; clothing poor; few recreational activities.

#### Northern Cape

West End 10 mentally handicapped patients integrated with 86 psychiatric patients in small wing of this tuberculosis hospital. Patients black and white. Food poor and inadequate; standards low; no recreational facilities.

#### Western Cape

Valkenburg Unspecified number of mentally retarded patients integrated with psychiatric patients in this 900 bed hospital. Part of the hospital is old, part comparatively new. Patients black and white. Allegedly whites are accommodated in new wards where conditions were "broadly

acceptable". Old wards described as "dungeons". Grave over-crowding; acute staff shortage; patients assaulted by staff; standard of care bad; wards "a shambles"; stench on wards "almost overpowering".

Lentegeur      800 mentally retarded patients integrated into with 752 psychiatric patients. Bed-linen clean; no overcrowding; gross staff shortage; morale among staff very low; incidence of substance abuse by staff/patients; allegedly frequent patient abuse by staff.

#### Free State

Poloko      250 mentally retarded patients including children integrated with psychiatric patients in this privately funded hospital. Total capacity: 540 beds for mentally handicapped/ 575 for psychiatric patients. Patients all black. Standards well below minimum; patients grossly neglected; food inadequate; blankets so thin they are useless. Documented evidence of patient abuse and malpractice. Sexual abuse of female patients by male patients allegedly rampant.

Weskoppies      Although this hospital is known by the writer to have mentally retarded patients in addition to psychiatric patients, no mention of these was made in the report. Conditions were



described as some of the worst seen, with the stench from the wards being "almost overpowering". Some wards are one hundred years old and had not been modernised.

Gauteng

- Strikland      192 mentally retarded patients integrated with psychiatric patients. Patients 99% white. Food; clothing; bed-linen; recreation facilities good; Physical restraint allegedly used.
- Tara            Unspecified number of mentally retarded patients, integrated with psychiatric patients. Patients mostly white. Living conditions; food; bed linen; clothing; recreational facilities very good. Physical restraint reportedly used on limited scale.
- Groothoek      Unspecified number of mentally retarded patients integrated with psychiatric patients. Patients all black. Clothing dirty; bed linen worn out, but clean. Reputedly a water shortage which accounted for patients clothes not being washed or changed for a week. Stench on wards "almost overpowering". Food poor; no recreational facilities; understaffed. Management/administration chaotic. Patients assaulted if they refused medication. Allegations

include: alcohol/cannabis abuse by staff and patients; frequent assaults and abuses on patients by staff; rape of patients by staff.

Millsite 400 mentally retarded adults and 300 mentally retarded children integrated with 2,143 psychiatric patients in this privately/state funded hospital. Patients 98% black. Appalling conditions; gross overcrowding, with this institution allegedly taking as many patients as possible; sub-standard diet; much verbal/physical abuse; assaults by staff; much drug abuse by staff /patients; no recreational facilities. A professional nurse made the following allegations: suspicion of falsification of death certificate; criminal activity among staff; sex between staff and young female patients; two professional nurses "often take female patients out at night to serve as prostitutes at a brothel."

Waverley 200 mentally retarded patients integrated with 317 psychiatric patients in this privately/state funded hospital. Patients all black. Gross overcrowding; mattresses "abominable"; patients allegedly search refuse bins for food; four children seen being fed off one plate; recreational facilities poor.

Kwa-Zulu Natal

Ekuhlengeni      Unspecified number of mentally retarded patients, including children, integrated with psychiatric patients. Patients all black. Evidence that clothing, bed-linen and blankets, normally dirty and worn out, were replaced by new items on day of inspection, then these were removed. This also applied to toys for the children. Patients supposed to feed spastic children, but they often ate the food themselves and the children went hungry. No control over sexual activities of patients. Ex-employee alleged girls of 12/13 yrs. sexually abused by adult male patients.

North West Province

Bophelong      68 mentally retarded patients, including children, integrated with psychiatric patients in the 640 bed psychiatric section of the public hospital. Almost entirely black. Buildings and conditions of wards poor; no cleaning staff provided; floors, linen and rooms all dirty.

Thabamoopo      Unspecified number of mentally retarded patients integrated with psychiatric patients. This hospital has beds for 1200 adults and 40 children, of these 984 were occupied. Entirely black. Below minimum standard.

It will have been noted that no comments have yet been included on bathing or toilet facilities. This is because, with the exception of the few buildings described as "new" or "modern", these were all found to be both inadequate and dirty, in several cases they were described as "filthy". The number of toilets per ward was rarely adequate. The Committee recommends one toilet for every four patients. What they found varied from thirty to one hundred patients sharing the same toilet. It was found that patients often had no privacy in the toilet or in the bath or shower. In many of the old hospitals the report, (p73), states, "The showers are designed in such a way they look like sheep dip kennels." (Sic)

To summarise the findings, the committee found that conditions of black patients in the former black hospitals or in hospitals in the private sector were the worst. Patients were frequently treated as sub-human and their right to dignity was violated. Clothes and bedding were washed irregularly and the presence of lice was suspected.

In general institutional food was often of poor quality, but the more frequent complaint was of insufficient quantity; clothes were often of poor quality, and bed clothes were frequently inadequate for cold weather. Very few institutions offered therapeutic treatment in any form to mentally retarded patients and overall recreational facilities were poor or non-existent.

With reference to staff, the committee found most institutions to be understaffed, with low morale very prevalent. Substance abuse (both alcohol and drugs), was rife

among staff, and in some cases among patients. The allegations of physical abuse, theft from patients and sexual abuse proved difficult to substantiate, because "most of those parties and individuals who offered help prior to investigation were not found to make submissions during the visits by the Committee." (Report of the Mental Health and Substance Abuse Committee p.83) One of the strongest complaints of the committee was of apathy, indifference or lack of co-operation among hospital staff.

The committee felt that sexual abuse was one of the most disturbing features of the violation of human rights. Staff at a number of the institutions attempted to assure the committee that such incidents were rare, but it was the feeling of the committee that incidents of sexual abuse were likely to be higher than admitted, and that internal investigation of such matters was rarely intense.

#### (i) Recommendations of the Committee

As the brief of the committee was intended to cover only conditions appertaining to psychiatric patients it is apparent that many of their recommendations were applicable solely to this class of patient. As stated at the beginning of this chapter psychiatric patients fall outside the parameters of this study and therefore the only recommendations quoted from the report are those which, in the opinion of the writer, could be applied to institutions housing both psychiatric and mentally handicapped patients. These recommendations have been summarised:

- a) Institutions are too large and too isolated. Both these situations need to be remedied.
- b) Humane standards of care should be developed.
- c) Regular inspections of institutions should be carried out.
- d) All patients should have the right to complain about their treatment without fear of victimisation. Each complaint should be thoroughly investigated by an independent body.
- e) Minimum staff/patient ratios should be laid down.
- f) Mentally handicapped patients should be housed separately from psychiatric patients.
- g) For every 4 patients 1 wash-basin and bath/shower with hot and cold water, and 1 toilet should be available and comply with minimum public health standards.

(ii) Conclusions Drawn From the Report by the Present Writer

One of the clearest conclusions to be drawn from the report is that persons with mental handicap are still perceived as second class citizens. In many cases they are denied the basic human rights of privacy and dignity; they have little recourse to appeal against abuse or cruelty. Racial distinctions continue, with black patients still being housed

in inferior accommodation, and allocated substandard clothing and food. Although, theoretically, all institutions are racially integrated, it would appear that this is not general practice. Some of the privatised institutions housing only black patients would appear to have the worst overcrowding, with the committee stating at one point that a certain hospital took as many patients as possible, in spite of gross overcrowding, obviously because this was the most profitable method of operating.

Earlier in this study the inception of three institutions, Fort England (1875), Fort Beaufort (1894) and Valkenburg (1891) was recorded. The first two were derelict military barracks, condemned as grossly unsuitable for use for mentally retarded patients, one hundred years ago.

The 1995 committee reports that Fort England now has modern buildings. Unfortunately evidence of improvements in patient care appear less apparent than the structural developments in many cases. In addition to drug abuse by staff, there was evidence of poor food; use of physical restraint; patients punished by being over-sedated and put in solitary confinement. It is clear that this institution has made little progress towards humanitarianism during the past century.

Fort Beaufort (now known as Tower) also possesses new premises and conditions are reported to be better than at Fort England. Whilst acknowledging the necessity to safeguard patients from possible sexual abuse, it is nevertheless

regrettable that the modern bathing and toilet facilities were so designed that patients are denied any form of privacy. One may also question why the hot water system was found to be totally inadequate.

It will be recalled that Valkenburg was opened as a mental institution in 1890, and it would appear, from the 1995 report, that some of the original buildings are still in use. From its inception Valkenburg adopted a policy of selective admission. Only those described by the first medical superintendent as "a curable class of white patients" were accepted. Today it would appear that this hospital still practises racial discrimination. Although patients of all races were admitted, the findings of the committee were that white patients were accommodated in "broadly acceptable" new wards, while the black patients were relegated to the old wards, described as "dungeons". As psychiatric and mentally handicapped patients are now integrated in this hospital one assumes patients are no longer divided into "curable" and "incurable" categories.

Valkenburg was one of three hospitals where the stench on the wards was described as "almost overpowering". In each case the ward in question housed only black patients. It would appear that standards in the old section of Valkenburg have deteriorated as the buildings aged. In 1995 the wards were found to be "a shambles", with a poor standard of care and patients being assaulted by staff. Grave overcrowding and acute staff shortages were blamed for this, which brings us to the crux of the matter.



High on the list of recommendations by the committee was an increase in staff. It is suggested by the present writer that although a more favourable staff/patient ratio would provide some relief to overworked staff this is only part of the problem. Members of staff are allegedly guilty of violence against patients, theft of patients' property, sexual abuse of patients, and the abuse of drugs and alcohol. The employment of extra staff is not going to eradicate these problems.

The nursing of persons with mental handicap is not an easy job. Recruiting staff of the right calibre for this work is difficult. To offer higher salaries as an incentive may appear to be the solution, but on the other hand, this may also attract people for the wrong reason. Ideally what is needed is a method of ensuring that staff are highly motivated, caring and well trained. It would appear that very few staff interviewed by the committee would measure up to these criteria.

In the opinion of the writer thorough inspections of all institutions on a regular basis are essential. It will have been seen, in the summary of recommendations, that such a course of action was advocated by the committee. However, it is suggested that their recommendation requires clearer definition. One needs to specify on whose authority future committees would operate and the precise parameters of their brief. It is suggested, once again, that such visits should be unannounced and that ample time should be allowed for detailed inspections and discussions with staff.

It is noted that the committee recommends the closure of the majority of institutions at present in operation on the grounds that they are too unwieldy and too isolated. No alternative method of accommodation is proposed in the report.

It is suggested that the only alternatives would be:

- a) the release of certain categories of patient into day-care facilities, and the building of smaller institutions for the remaining patients.
- b) to emulate a system of de-institutionalisation similar to that undertaken in the United States and in England.

With regard to paragraph a), one of the complaints of the committee was the isolation of present institutions. To alleviate this problem any new facility would need to be in close proximity to urban areas. It is unclear from the report whether the committee was advocating less isolated areas in order to facilitate easier access for visiting families, or whether they felt the patients should be integrated into local communities. While both reasons are commendable, it is suggested that in the present economic climate any such large-scale programme stands little chance of being implemented.

With regard to paragraph b), these schemes allow all patients to be moved into small "group homes", or, if

considered suitable, into an apartment shared by one or two other former patients, under the supervision of a visiting social worker. While theoretically the idea of rehabilitating persons with mental handicap into the community may sound commendable, it should be stressed that in practice such schemes have been found to be problematic and extremely expensive. Once again it is suggested that, at the present time, the South African government will be unlikely to expend its over-stretched resources on financing any such major project for what might be termed "this minority group".

Low-cost housing, education, job creation and general hospital services are all vote-catching projects which politicians choose to embrace. The issue of improved amenities for the mentally retarded is unlikely to have popular political appeal.

The feeling of the present writer is that few, if any, major building programmes are likely to be undertaken in the near future. Neither is the implementation of extra, well-trained, motivated staff likely to occur unless conditions of employment improve. It is suggested that if the promised White Paper on disability is published the recommendations are likely to remain theoretical rather than practical.

d) Government Gazette No.17038:  
Integrated National Disability Strategy of the Government of  
National Unity 1996

In earlier chapters the connection between the rise of capitalism and the emergence of the asylum system in England during the mid-nineteenth century has been discussed. The relationship between the perceived need to control non-productive members of society and the growth of industrialisation was considered.

The social and political change which South Africa is undergoing in the 1990s could be seen as a parallel to the changes wrought in Europe by the so-called "Age of Revolutions" of the nineteenth century. Every aspect of life will be affected by a new set of values and ideas which are, in many ways, revolutionary to the old regime.

The predominant theme throughout the Government Gazette No.17038 is the apportioning of blame for the ills of the present to the apartheid system of the past. The system is accused not only of allowing the marginalisation of handicapped persons, but of creating handicap through the condoning of poverty.

In a foreword to the document which declares the strategy of the Government of National Unity in consultation with the National Coordination Committee on Disability and Disabled People, Jay Naidoo, Minister in the Office of the President states:

"The Interim Constitution recognises the equal rights of disabled people. Giving effect to the constitutional principles requires a commitment from government and civil society, to redressing the imbalances and creating an enabling environment for people with disabilities."

(p.5)

Naidoo goes on to state that this is a discussion document which requires comment from " individuals and organisations of and for disabled people across the country" and that on the basis of these inputs Government will publish a White Paper on disability. The deadline for submission of comments was 31st. May 1996.

At the time of writing it would appear that the compilation of the proposed White Paper is still underway, therefore Government Gazette No.17038 of 1996 can only be discussed as a proposal paper. It should be stated that this document is intended to cover all forms of disability, both physical and mental.

The principal points of focus contained in the document are:

- a) That persons with disabilities are members of society and have equal rights. As they achieve these rights so they should have equal responsibilities and provision should be made for them to assume their full responsibility as members of society.

- b) Provision for the handicapped should cease to be a health and welfare issue and become the responsibility of the Reconstruction and Development Programme. It is argued that dependency on a welfare model isolates disabled people and marginalises them from society.
- c) That development's ultimate goal is an inclusive society which recognises and values individual difference and acknowledges common humanity and equality.
- d) The need for the amendment of the Mental Health Act No.18 of 1973 on the grounds that this not only fails to afford sufficient protection to people with mental disabilities, but is inherently open to abuse and falls short of the United Nations principles on Human Rights.

With regard to the issue of provision for the handicapped mentioned in paragraph b), it would appear that events have overtaken this proposal before it could be finalised. At the present time the government is suggesting that each department must decide on its own priorities and accept responsibility for these. In effect such a move would mean that provision for the handicapped could not become the responsibility of the Reconstruction and Development Programme as proposed in the Gazette.

Part Two, Section 2, of Government Gazette No.17038 of 1996 discusses the National Year of Disabled Persons, held in South Africa in 1986. It appears that investigations carried out during that year by both the government and non-governmental organisations revealed "the complete absence of any workable policy on disability and gross discrepancies in the few services which existed, both in racial and in terms of rural/urban distribution of services."

Following the above investigation an Interdepartmental Coordinating Committee for the Care of the Disabled was established. This included state departments in addition to the non-governmental organisations and their aim was to implement the various recommendations arising out of the 1986 investigations. By the end of 1991 the committee had failed to implement any of its tasks and was subsequently disbanded. (p.27)

In 1991, the year the above Committee was disbanded, the Disability Rights Unit of Lawyers for Human Rights, together with Disabled People South Africa, commenced work on a charter of demands of disabled people in this country. The final charter was adopted by the Disabled People South Africa Council in December 1992. This document "asserts the right of all disabled people to live independently in a safe environment and in a society free from all forms of discrimination, exploitation and abuse."

The conditions in psychiatric hospitals described in the report of the Mental Health Committee in 1995 (quoted earlier in this chapter) suggest that although this charter was published, the mechanism to promote the ethics stated therein was never implemented.

Part Three of Government Gazette No.17038 of 1996 presents what it terms a "Vision - A Society for All" This includes people with disabilities being a natural and integral part of society, with opportunities to contribute their experience, talents and capabilities to national and international potential. It foresees the concept of a society for all, encompassing human diversity and the development of all human potential.

The vision is commendable, but it is feared, illusionary, at least as far as it concerns persons with mental handicap. The recommendations made by committees over the years have been meaningless and these people are still marginalised. The language has changed, but society does not perceive persons with mental handicap as "a natural and integral" part of the community. Until they are accepted as such then the concept of equality remains an illusion.

As stated earlier, it is clear from the tone of the document that blame for the inequality of the handicapped in South African society is placed on the years of apartheid government. Section 1.5 claims that:

"The nature of the inequalities which disabled people in South Africa have experienced have been defined by the system of apartheid, where these policies have not only been a major cause of disability but have also created significant under-development and poverty among the majority of disabled people, especially in the rural areas." (p.15)



It is suggested that greater progress towards equality for the disabled might be achieved if there was less prominence placed on the iniquities of the past and more emphasis given to the practical application of available resources for future use.

e) Changes in Terminology Recommended in Government Gazette No. 17038 of 1996

At the commencement of this study it was stated that the terminology used would be that which was in common usage at the period under discussion. Consequently the terms "lunatic" and "the insane" were used in the early chapters, and these were later replaced by "feeble-minded" and "mentally retarded".

Contrary to the custom in England, South Africa has continued to use the terms "mentally retarded" and "mentally handicapped" up to the 1990s. Only recently have there been proposals for change. The apparent reasons for changes in terminology will be discussed in the following chapter. However, while discussing Government Gazette No.17038, it should be mentioned that the need for certain changes in definitions is recommended.

The only recommendation falling within the parameters of this study is that the term "retarded" be replaced with "persons with mental handicap". The new terminology suggested in Government Gazette No. 17038 is likely to be considered more acceptable by those working in the field of mental health, focusing as it does on the person, not on the disability.

f) Government Gazette No.1711136 South African Schools Bill  
1996

The above document has little relevance to children with mental handicap. Chapter 4 deals briefly with "Learners with Special Needs in Education" and states that:

- a) The Member of the Executive Council may establish and maintain special public schools to provide education for learners with special education needs.
- b) Where reasonably practicable, education for learners with special education needs will be provided as in ordinary public schools.

The remainder of Chapter 4 of Government Gazette No 17136 is concerned with the representation of these children on the governing body of an ordinary public school by a person or persons with expertise in special education needs.

The brevity of the section on special educational needs in the government paper would appear to endorse the feeling that this is not perceived as an area of importance within the general education field.

It will be noted that the word "may" is used in reference to the establishment and maintenance of special schools. One wonders if this implies no firm commitment on the part of the government to continue with this type of education.

It is also noted that no reference is made to the provision of special classes in ordinary schools, thus it is unclear whether this is to be the government policy or whether they are proposing integrating learners with special educational needs into the ordinary classroom.

g) The Implications of the South African Constitution  
1996 for Mentally Handicapped Persons

Chapter I closed with an extract from a speech made by Dr. William Roland, President of the South African Association for the Blind, at a conference on Affirmative Action and the Disabled in May 1994. Roland called for all organisations involved with the physically or mentally disabled to seize the opportunity to have a clause written into the new Constitution granting equality to the disabled.

Although the conference did not take a resolution on this recommendation, the mood was positive and a strong feeling of support was generated. The writer was among those who looked forward to the publication of the Constitution document.

It has already been stated in this study that although the Constitution was finally adopted by the Constitutional Assembly on the 8th. May 1996 certain political parties called for a number of amendments. In consequent of this an amended Constitution was only submitted to the Constitutional Court on the 11th October 1996. None of the proposed amendments concerns the present study.

Although there is no specific mention of persons with handicap, it would appear that the expectations of the Conference on Affirmative Action and the Disabled in 1994 have been met:

"This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."

Section 9.1 states:

"Everyone is equal before the law and has the right to equal protection and benefit of the law."

Section 9.3 states:

"The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth."

One would like to feel encouraged by the fact that persons with any form of handicap are not singled out for special mention in the Constitution document. Taking a positive view, it is assumed that they will be guaranteed the same rights as other citizens.

Unfortunately, from a practical viewpoint, this appears to be an idealistic approach. When one considers the huge expenditure which would be involved in providing decent living conditions and adequate educational and training facilities for those persons with mental handicap at present being deprived of such amenities one realises the improbability of such a task. Given the present economic climate in South Africa it would be almost an impossibility.

Section 29, Chapter 2 is headed "Education". No mention is made of provision for learners with special needs. Section 29 (1) (a) merely states:

"Everyone has the right to a basic education."

The report of the Committee to Review the Organisation, Governance and Funding of Schools, (1995) mentioned earlier in this chapter, states that an investigative committee into the requirements of learners with special educational needs was to be formed. It may be the intention of the government that this committee will ultimately issue a White Paper covering this area, and that additional coverage in the Constitution was therefore unnecessary.

Although this reasoning has been proffered as a suggestion for what would otherwise appear to be a serious omission in the constitution, it must be added that such a document would cover only the educational aspect of mental handicap. Adults, and those children considered ineducable, would fall outside that sphere.

Section 184, Chapter 9 of the Constitution is headed "Human Rights Commission". One would hope that the rights detailed below are intended to include persons with mental handicap, although no mention is made of any specific group.

(1) The Human Rights Commission must-

(a) promote respect for human rights and a culture of human rights;

(b) promote the protection, development and attainment of human rights; and

(c) monitor and assess the observance of human rights in the Republic.

It is clear from the preamble where the central focus of the Constitution lies:

(To) "Recognise the injustices of our past;"

"Honour those who suffered for justice and freedom in our land;"

"Respect those who have worked to build and develop our country;" and

"Believe that South Africa belongs to all who live in it, united in our diversity."

(p.3)

Throughout the apartheid era the conflict between black and white was an issue which predominated over all others. One cannot minimise the racial injustices of apartheid South Africa and the need to redress these wrongs is clearly the paramount concern of the new Democratic Government. To use a current term, "previously disadvantaged communities" are, under the new Constitution, to be provided with citizenship; equality in law; the right to human dignity; freedom of religion and political belief; to housing; welfare/health services; employment, and education. This is as it should be, and few would argue with the principle.

However, it is hoped that in seeking to redress the wrong done to the black majority, the new constitution will not ignore the wrong done to other minority groups, among whom are those persons who are physically or mentally handicapped. Such persons also belong to "disadvantaged communities". For the purpose of this study only the mentally handicapped will be discussed, but equally penalised are those who suffer from physical handicaps and for whom the new Constitution makes no specific mention.

As stated above it had been hoped that the issue of rights for the handicapped would be specifically recognised in the new Constitution, but the only mention of any form of handicap would appear to be in the recognition of sign language. In Section 6.5 Chapter 1 the Pan South African Language Board is instructed to:

- 6.5 (a) "promote and ensure respect for" minority languages, including sign language, in addition to the eleven official languages.

In theory the rights laid down in the Constitution apply to all South Africans, but it is contended that for the mentally handicapped, in particular those in institutions, such rights are meaningless. If one recalls the prevailing conditions in many of the institutions, as recorded in a previous section of this chapter, one wonders how these can be equated with the "human dignity, achievement of equality (and) the rights, privileges and benefits of citizenship" as laid down in Chapter I.1.(a) of the Constitution.

If the new Constitution is to have any meaning for the mentally handicapped, it is suggested that there is an urgent need to implement in particular the points of the Constitution quoted below:

Chapter 2    7.1...The rights of all people in our country...to the democratic values of human dignity, equality and freedom.

- 9.1 Everyone is equal before the law and has the right to equal protection and benefit of the law.



9.2 ...To promote the achievement of equality,  
legislative and other measures designed to protect  
(persons) disadvantaged by unfair discrimination ..

12.1(e) (Everyone has the right) not to be treated or  
punished in a cruel, inhuman or degrading way.

28.1(d) (Every child has the right) to be protected  
from maltreatment, neglect, abuse, or  
degradation.

As stated earlier it is suggested that the Constitutional Commission would have done well to specify that the "disadvantaged communities" in South Africa are not only those who suffered from racial intolerance during the apartheid era.

#### h) Employment and Occupational Equality Green Paper

On July 1st. 1996 the government released the Employment and Occupational Equality Green Paper which purports to "minimise barriers to people from historically disadvantaged groups and accelerate their hiring, training and promotion."

At the time of writing no copies of this document were available in Department of Labour offices. Accordingly the writer could only assess the contents of the Green Paper from the information released to the press.

As might be expected, the central focus of the document appears to be on the need to equalise employment opportunities between the racial groups and includes a proposal that

qualification requirements be lowered "in view of the considerable racial gap in education". However, it is encouraging to note that the proposed equalisation plans would appear to include disabled persons. The press report contains only a brief mention of this group, but the full report is awaited with anticipation.

## Chapter XII

### Conclusion of this Study

It was the stated aim of this work to illustrate the shifts in societal perception of mental retardation concurrent with social, political and economic change in South Africa. Legislation was traced from the Lunacy Laws of the Cape Colony in the early nineteenth century to the new Constitution of 1996. Provision to meet the physical needs of persons with mental handicap was researched over a similar period.

In order to comprehend any change one must first observe evidence of earlier conditions. The present chapter will therefore follow this course and will, at the same time, draw together the threads which have emerged during this study.

Where meaningful change has taken place, an attempt will be made to access what factors, i.e. social, political or economic, lay behind such a move. Similarly, where lack of movement is discerned, the reasons for apparent lassitude will be sought.

The examining of the implications of this study and the specifying of conclusions will be divided into three main sections, with sub-divisions under appropriate headings:

#### A. Conclusions to be drawn from this study.

- (a) Shifts in Legislation Appertaining to Persons with Mental Handicap

- (b) Shifts in Perception of the Physical Needs of Persons with Mental Handicap.
- (c) Shifts in the Provision of Special Education.
- (d) Periods Judged to have Particular Pertinence to this Study

A. Conclusions to be Drawn from this Study:

This section begins by highlighting the focus in legislation over the period covered by this study. It continues by pin-pointing the shifts in the provision of physical needs and of special educational needs to persons with mental handicap. The section will end by selecting the areas, which in the opinion of the writer, have the greatest pertinence in this area of study.

(a) Shifts in Legislation Appertaining to  
Persons with Mental Handicap.

The writer asserts that the focus a society places on the mentally handicapped at any given time is reflected in the emphasis of the legislation that is promulgated in their

interests. Accordingly this section will commence with a summary of legislation covering the time span under study and the conclusions to be drawn from the shifts in emphasis detected by the writer.

It is suggested that the South African legislative provision for lunatics in the nineteenth and early twentieth centuries can be viewed from a series of separate, yet interconnected, perspectives. These divisions are illustrated below, with the centre of focus during each period included.

(i) The Developing Colony - Focus: Property Rights

It has been noted in Chapter VI that under Dutch rule legislation appertaining to lunacy in South Africa dealt solely with the property of the alleged lunatic, and made no provision for his welfare. The earliest traceable references to similar legislation under British rule, Cape Ordinances No. 5 of 1833 and No.3 of 1837, also referred to in Chapter VI, followed the same pattern.

Under Roman-Dutch law a person defined as a lunatic by the existing legal process was dispossessed of his property rights. Such rights were granted to the nearest male agnate. Thus the property of the alleged lunatic would be safeguarded for the family. Unless considered violent or dangerous, it seems likely that the so-called lunatic would have remained within the custody of his family or the community. Here he could, in all probability, contribute by performing tasks requiring physical strength rather than mental ability.

Viewed in this light, these ordinances, relating only to the property or estate of the alleged lunatic, and making no provision for custodial care, appear a rational course. They deal with practicalities at a time when prevailing conditions rendered such an approach to be of paramount importance.

(ii) The Emerging Infrastructure - Focus: Certification and Control

By the second half of the nineteenth century the infrastructure of South African society was being developed territorially, industrially, commercially, and through legislature. Commensurate with these developments came the perceived need to "legitimise lunacy":

Between 1868 and 1897 the four territories each promulgated a law governing the certification of alleged lunatics, each specifying a similar procedure. Almost simultaneous with the promulgation of the new legislation came the establishment of asylums. The policy of legislative control of lunatics had begun.

Although there were insufficient of these to warrant the term "asylum system" by European standards of the day, such institutions were constructed nationwide. By the end of the nineteenth century Natal, the Orange Free State and the Transvaal had each provided one asylum, while the Cape Colony had a total of five such institutions.

It is suggested that this was the beginning of stricter legislative control over alleged lunatics, and it can be no coincidence that this ran parallel to the shift towards an industrialised and capitalist society in South Africa.

(iii) The Spread of Urbanisation - Focus: Eradication of Vice and Crime Allegedly Attributable to Mental Defectives.

As South Africa continued to develop a more highly industrialised economy, so the laws to control the mentally defective increased. The rapid spread of urbanisation around the goldfields and diamond mines predictably increased the level of crime and vice in those areas. Concurrent with the rise in the crime rate, reports from government agencies on mental health began to suggest that mental deficiency was synonymous with moral deficiency. This equation, once propounded, appears to have dominated the field of mental health from 1918 until the mid 1930s.

(iv) Post-Union Legislation - Focus: Classification of Mental Deficiency

In 1916 South Africa witnessed an important change in the area of mental health. The Mental Disorders Act No.38 recognised mental deficiency as a separate category from mental illness. Furthermore, mental deficiency was divided into seven different categories. Although the act fails to define the immediate purpose of this classification it did lead the way to an extension of control.

Persons with more severe mental handicap continued to be certified and confined to mental institutions, but for those with a milder handicap the perceived need was that they should be identified. It would appear that the focus was on children with mild handicap. The act recommended that separate accommodation be provided for them and that reasonable provision be made for their care and instruction. Unfortunately it was to be some considerable time before this recommendation was implemented.

(v) Post World War I - Focus: Education and Training of  
Mentally Defective Children.

It was stated in Chapter IX that prior to the 1920s little or no mention is made of legal provision for children with mental handicap. It appears likely that children with mild handicap remained in the custody of their families. The same may also be true of children with more severe handicap, but it is possible, particularly in the case of older children, that they were committed to asylums with adults.

The first legal provision in South Africa for children with mental defect would appear to be The Vocational Education and Special Schools Act No.29 of 1928. Theoretically this law made provision for the education of children with physical or mental defects throughout South Africa. In practice this applied only to white children, as did all other legislative Acts appertaining to special education until the 1960s.



Even for white children, the recommended special educational facilities failed to materialise. As stated in Chapter IX the Inter-departmental Report on Deviate Children in 1945 found that the promises of the legislation of the 1920s and 1930s remained unfulfilled.

In mitigation of this dereliction one must consider the economic situation during that period. The 1920s and early 1930s were the era of the Depression, followed in 1939 by six years of war. Given this background it is hardly surprising that special educational needs, whilst recognised in law, failed to be met.

(vi) Formalisation of Apartheid - Focus: Racial Issues.

There would seem to be less justification, however, for the scarcity of legislative activity relating to the mentally defective during the 1950s. It may be that the South African government was too immersed in implementing the multitudinous laws of the apartheid system to spend time on other legislative matters.

The next plethora of acts, during the 1960s, reflected the separate development policy. For the first time legislation specified the need of special educational facilities for non-European children. While the Coloured children with mental and physical defects were covered by Act No.47 of 1963, and Indian children, with similar defects by Act No.61 of 1965, Act No.24 of 1964 relating to black children referred only to

those with physical defects. Thus, by omission, mentally handicapped black children remained excluded from special educational facilities. This situation was to last another fifteen years, until the promulgation of Act No.90 in 1979.

Although theoretically the 1979 act granted the right of special education to mentally handicapped black children, so little provision was forthcoming that the act appears to have been little more than window-dressing. It would probably be fair to say that this could be applied also to mentally handicapped coloured children. If the Indian children fared better it was largely due to the financial support of the Indian community, as indicated in Chapter X.

The flurry of legislation appertaining to special education for non-European children may have been occasioned in the 1960s and 1970s because the South African government felt a demonstration of apparent parity across all racial groups would help, in some measure, to appease international abhorrence of the apartheid system at a time when much attention overseas was being focused on disability. Unfortunately most of the provisions the South African government committed to paper failed to materialise.

All the acts mentioned above made provision only for children with mild mental handicap. It was not until 1974 that Act No.63 made provision for the training of children with more severe handicap. In 1988 Act No.63 was repealed. Although the wording of the replacement act, No.70 of 1988, was somewhat ambiguous, theoretically it covered the education of both the mild and severely handicapped child.

(vii) The New Democratic Government - Focus: Equality  
for All.

The new Constitution of 1996 is, as one might expect, the document which could have the more far-reaching results of any legislation promulgated hitherto. The Constitution gives all persons with mental handicap equal rights with every other citizen of the Republic of South Africa.

Unfortunately it appears that this document presents an idealistic discourse on human rights, rather than a clear commitment to enforcement through a code of practice.

The implementation of such a proposition for persons with mental handicap, socially and economically, are tremendous. Given the current social and economic climate in South Africa, it seems unlikely that much will be accomplished in the short term. The government would need to be prepared to allocate an enormous sum for the re-location of those persons with mental handicap who at present are housed in deplorable conditions in mental institutions. In the present economic climate such a commitment appears unlikely.

b) Shifts in Perception of the Physical Needs of Persons with  
Mental Handicap

Chapter IV presented coverage of the accommodation available for lunatics in South Africa at the close of the

nineteenth century. In order to compare these perceived needs with those of the present-day an approach was made to many of the mental institutions currently in South Africa, asking for information regarding patient capacity and the facilities available. Unfortunately the response was too poor to provide meaningful statistics and therefore use has been made of the report of the Mental Health and Substance Abuse Committee of 1995, discussed in Chapter XI.

This report contained details of conditions in seventeen of the institutions accommodating persons with mental handicap and the following conclusions have been drawn from this document.

i) Despite the theoretical abolition of racial barriers in mental hospitals very few appear to be racially mixed. Where movement has been noted it has been a black patient moving to a hospital previously reserved for white patients, never the reverse.

ii) Living conditions of black patients continue to be vastly inferior to those of white patients.

iii) Although drug and substance abuse, and the ill-treatment of patients, was only reported in wards housing psychiatric patients, the writer suggests it seems likely that this also occurs in the wards housing mentally retarded patients under similar circumstances.

iii) Better facilities in the form of special education, sheltered workshops and the chance of living in a residential home funded by a mental health

society (state subsidised) are all possibilities for persons with mild retardation. If their finances permit, they may also be admitted to a small privately funded home. Persons with severe retardation have little choice. They remain either in the large state-funded institutions; in the frequently appalling conditions of the state/privately funded institutions, or, in the rural areas, with their families.

In the opinion of the writer, it appears unlikely that any meaningful improvement in the physical provision for persons with mental handicap will take place in the immediate future. It would seem that their needs are overshadowed by claims for housing, education and employment by previously disadvantaged communities.

c) Shifts in the Provision of Special Education.

It was shown in Chapter IX that the perceived need to provide educational facilities for those termed "imbecile children" was first recorded at Grahamstown Asylum in 1894. The implementation of such facilities was repeatedly urged throughout the second decade of the twentieth century, firstly by the South African Society for the Care of the Feeble-minded in 1913, and later in the 1918 report of the Commissioner in Mental Disorders.

In spite of the above requests, the de Vos Malan report (1945) records that by 1929 there were no special classes in the Orange Free State. The Cape Province had three special classes, the Transvaal had eight, while Natal had two special classes and one special school. It has been noted in Chapter IX that special educational facilities increased at a slow rate over the next two decades. This was a period of economic depression, followed by six years of war and it is suggested that the development of educational facilities for children regarded as feeble-minded was not high on the list of governmental expenditure.

If special educational facilities for white children had low priority, similar amenities for children of other races were non-existent until the 1960s, when legislation appertaining to this issue was passed. It will have been noted in Chapter X that the physical provision of special schools for non-European children lagged far behind the requirements of the law.

By the early 1990s all special schools were racially integrated, but it is noted that the formerly white schools continue to be predominantly white. However, the movement of black pupils into formerly white schools appears to be greater than the movement of black patients into formerly white mental institutions, as mentioned in the previous section.

It is concluded from the research undertaken that the most problematic areas are:

- i) the uncertainty over future funding of special schools in the present economic climate.

- ii) the numbers of black children with mental retardation as yet unidentified in the rural areas.

d) Periods Judged to have Particular Pertinence to  
this Study

This section will end with a survey of the shifts in perception during the periods judged by the writer to be the most relevant to the present study. The foregoing chapters have covered meaningful changes in many areas, but it is mooted that the periods which made the most impact upon provision for persons with mental handicap are:

i) Control. It is suggested that the first evidence of the imposition of state control appeared in 1846 when, at the instigation of the British Colonial Secretary, the so-called lunatics were transported from the mainland to the recently vacated convict colony on Robben Island. Although, as stated in Chapter III, thirty-eight of these patients were transferees from Somerset Hospital, it is contended that this move is the first sign of government intervention in the placement of alleged lunatics.

It will have been noted that Somerset Hospital was originally a privately-funded institution and was later administered by the Burger Senate. Although it would appear to have had a certain amount of government approval, there is no trace of it ever coming under the auspices of the Colonial authorities.

Not only did the 1846 transfer of lunatics herald the onset of governmental control, but, as shown in Chapter III, it

represented a masterstroke in economic planning. Not only were the lepers and lunatics removed from the vicinity of Cape Town at little cost, but a convict labour force was now available to work on the mainland. This would appear to be the first recorded instance of governmental economic strategy affecting the welfare of lunatics in South Africa.

ii) Consolidation. If the foundations for state control of lunacy were laid in 1846, then it may be said that the final quarter of the nineteenth century witnessed its consolidation. These were years which saw South Africa's growth towards industrialisation and capitalism. They were also years when a total of eight legislative Acts appertaining to lunacy were promulgated nationwide, and when seven mainland asylums were established. State control was expanding. Whereas, up to this point, alleged lunatics had been housed in local gaols or hospitals, or on Robben Island, (the only available asylum) now control was being centralised in provincial asylums.

It has been shown in Chapter V that authorities nationwide seriously underestimated the number of beds which were likely to be required. While accommodation for lunatics had been limited to Robben Island in the Cape Colony and local prisons or hospitals elsewhere, the number of those identified and confined to institutions would, of necessity, remain small. While never, in any way, emulating the increase in patient numbers experienced in England in the mid-nineteenth century, it is probable that the opening of asylums throughout the provinces led to an escalation in the number of admissions of persons with, in present day terms, severe or profound retardation. Such persons would previously have remained, unidentified, in the care of their families. Now they became statistics in the admission lists of asylums.



It is not known whether the size of the asylums was determined by economic restrictions or by an estimation of prospective patients. If the latter was the case, then it appears likely that too little time, and money, was expended on assembling information on the number of lunatics already needing accommodation, either because they were housed in gaols or hospitals, or because they were in the care of their families. It may be suggested that such inadequate planning, either from reasons of economy or from miscalculation, could be seen as indicative of the scant attention given to the needs of the allegedly insane towards the end of the nineteenth century. Not only were the newly created asylums inadequate to meet the current needs of the population, but it appears that no thought was given to the inevitable percentage of mental defectives among the ever-increasing immigrant population.

iii) Identification. The Mental Health Act No.38 of 1916 is seen as a major breakthrough in the classification of mental deficiency and in defining mental illness as a separate category from mental deficiency.

Firstly, it is suggested that this Act saw the beginning of mental retardation as a socially constructed condition in South Africa. Those who had hitherto remained, unidentified, within the community, were now labelled as feeble-minded. They fell within the classification of mentally defective and came under tighter governmental control.

Secondly, prior to Act No.38 attention had been focused on lunatics regarded as certifiable and confined to asylums. Now mental health authorities were to change direction and concentrate almost exclusively on those classed as feeble-minded.

Thirdly, this act places emphasis on the provision for patients seeking voluntary treatment for mental illness. It should be borne in mind that this act was promulgated midway through the first World War. Troops returning from trench warfare, suffering from shell-shock, (now known as post-traumatic stress) may have been in need of voluntary admission to the mental hospitals.

iv) Discrimination. The era of the Depression, the 1920s and early 1930s, was a period in South African history when the perceived worth of the so-called feeble-minded was at its lowest point. As stated in the previous section, emphasis shifted from the small percentage of the population who were certifiably insane to the far greater numbers with mild mental retardation.

Chapter VIII has discussed the alleged correlation of poor whiteism and feeble-minded. It is now suggested that this was considerably exaggerated by the Commission in Mental Disorders in 1918 and that the poor whites were not alone in being the progenitors of this condition. It was also shown in Chapter VIII that the feeble-minded were perceived to have a disproportionately high proclivity towards vice and crime.

The writer would assert that the feeble-minded were placed

in the role of scapegoats. It was a time of economic, social and political upheaval, when the accepted social and moral standards of the dominant white South African were seen to be eroding. Throughout history it has been convenient to blame a scapegoat in times of crisis. It is suggested that, in this instance, the scapegoats were the feeble-minded. Not sufficiently articulate to defend themselves, not politically powerful, described as "socially and morally bankrupt", they were the perfect candidates for the role.

The proposed solution to the problem was seen to be the confinement of the feeble-minded in sexually segregated colonies, usually in the form of farming settlements. According to the advocates of this policy, Dunston and Gundefinger among them, such a scheme would not only rid society of crime, but it would stamp out feeble-mindedness in three generations. Why such schemes were not implemented remains unexplained. The writer would suggest that the government was unwilling to engage in the expenditure of establishing these colonies at a time of financial crisis. It is interesting to note that no recorded objections to these proposed schemes could be traced.

iv) Equality. Chapter XI included sections from the New Constitution granting equal rights to every South African. At the present time it is too early to know the extent to which persons with mental handicap will benefit from this inclusion.

As might be expected, the focus of the document centres almost exclusively on redressing the wrongs suffered by the "previously disadvantaged" communities. It has been suggested

in Chapter XI that persons with mental handicap have also been "previously disadvantaged."

Given the focus of the constitutional document, the writer concludes that the chances of redress for the mentally handicapped, at least at the present time, are minimal. It had been hoped that the Constitution would include discourse about disability in more explicit terms. Unfortunately it centres around equality issues of race and gender.

#### The Strengths and Limitations of the Present Study

In Chapter I it was stated that the initial motivation for this study stemmed from a speech made by Dr.P.H.du Preez, Director: Schools for Specialised Education, in 1992. Du Preez announced that Saamstap School, which had provided education facilities for children with moderate or severe mentally handicap, would be closed. The reason given was that:

"...in the present economic climate the money available must be spent on normal children who will one day have the skills to offer in the marketplace."

If this was the expressed policy of a government department then it appeared likely that in periods of economic downturn persons with mental handicap would be among the first to suffer deprivation, not only in educational facilities but also in the provision for the needs of those in institutions.

It was therefore decided to research this issue. It was not the intention to provide a complete historical account of mental retardation in South Africa, but to identify changes in legislation, in social forces and in the language

appertaining to persons with mental handicap. The decision to either include or omit certain historical data was made on the basis of its perceived relevance to the central focus.

Research began with the perusal of all available acts of legislation appertaining to lunacy in the Cape Colony during the eighteenth and nineteenth centuries. In conjunction with this a search was begun to gather information on the early asylums. A number of the institutions approached provided historical background, but others failed to respond. Fortunately it was discovered that reports from the Medical Superintendents of all the asylums founded during the final years of the nineteenth century had been included in the report of the Commissioner in Mental Disorders for 1918. These provided accounts of patient numbers, details of accommodation and the amenities available. In some cases it was possible to gain a certain amount of knowledge on the attitude of staff towards patients from the inference of the reports.

The reports from the Commissioner in Mental Disorders (later to be known as the Commissioner for Mental Hygiene) followed at approximately two-yearly intervals until the early 1930s. These documents proved invaluable in revealing the attitude of this Commission towards the allegedly feeble-minded during the years of the Depression. The emphasis in these documents was on the supposed correlation between the poor whites and feeble-mindedness. Consequently all available documentation on poor-whiteism was researched. Many of the accounts focused on the socio-political aspects of mass unemployment and therefore had to be disregarded, but the report of the Carnegie Commission of 1934 proved a useful source.

Throughout the period of research primary sources in the form of Parliamentary Acts; the report of the van Schalkwyk Committee, 1928/30; the de Vos Malan Committee, 1945; the reports of the Commissioner in Mental Disorders (mentioned above) and Hansard 1975-79 were to prove a valuable fountain of information. The use of newspaper articles began with the advertisement for the opening of Somerset Hospital in the African Court Calendar of 1823 and continued through the exposure of the Smith, Mitchell scandal in the Sunday Times in 1975, up to the latest reports on conditions at St. Annes Hospital contained in the Daily News (Durban) 1995.

Unfortunately there were times when information was not forthcoming, despite a thorough search. In Chapter V the absence of statistics showing patient numbers at the end of the nineteenth century, precluded a fuller coverage of this subject. However it was felt that the data which was available was sufficient to make the statistical tables, included in an addendum, meaningful.

There were occasions when research revealed a fascinating lead, only to end without further trace. A case in point was the item gazetted under the Temporary Loans Act No.17 of 1894, mentioned in Chapter V of the present study. A sum of forty thousand pounds was apparently granted to Valkenburg Asylum for constructing and equipping an asylum to adjoin the present institution. No record of such an extension could be traced, nor does the Valkenburg Centenary Brochure mention either the loan or the extension.

Although the chapters throughout this work have been generally organised in chronological order, it was decided that certain areas should be dealt with separately.

Consequently the coverage of special educational facilities, and of racial issues has been allotted individual chapters, rather than being interspersed with other areas in order to maintain strict chronological sequence.

It had not been envisaged that current information and statistics on the area of mental health would be virtually unobtainable at the present time. Although every effort was made to obtain details of the provision of accommodation for persons with mental handicap on a provincial basis, or on the availability of special education facilities, these were fruitless.

It would appear that the writer seriously underestimated the administrative upheaval caused by the demise of the former provincial education authorities, and of their amalgamation into one national body.

The publication of the report of the Mental Health and Substance Abuse Committee of 1995 coincided with the later stages of this study and it was most opportune that their observations could be included.

The new Constitution in its original form was promulgated in May 1996, thus enabling the writer to include observations of this document in the penultimate chapter of the present study. Although the Constitution has, at the time of writing, been withdrawn to allow for further consideration, the points under review are unlikely to affect the conclusions reached in Chapter XI.

In attempting to assess the strengths and limitations of this work it was felt one needed to determine the persons most likely to gain any knowledge from it. The framework of this study has been built on the identification of periods in the history of mental care in South Africa when there has been a discernable shift in the control of persons with mental handicap and of their perceived needs.

It has been the experience of the writer that those working in the area of mental health, be they teachers, social workers or nurses, have little background knowledge of how societal attitudes towards mental retardation were formed. It is argued that without this knowledge much of the relevance of present-day attitudes is lost. It has, therefore, been the aim of this study to research the shifts in societal perception of mental retardation in South Africa in an attempt to, at least partially, fill that gap. It is hoped that this has been achieved.

#### c) Indications for the Approach to Subsequent Research

It was always the intention of the writer that this study should present a generalised overview of the shifts in societal perception of mental retardation in South Africa during this period. Consequently this work has touched on many facets including the legislative provision for persons with mental handicap; the standard of their accommodation and the educational facilities for children with special needs.

This overall approach was selected in preference to an in depth study of one particular aspect of public perception and in retrospect it is felt that this strategy was justified.



The acts of legislation investigated in the course of this work provided considerable insight into the attitudinal changes of the law-makers with regard to mental handicap. The interest of the writer was furthered by the perusal of the Parliamentary debates, reported in Hansard, in relation to the Smith, Mitchell scandal over institutional accommodation in 1975. (Chapter X) This line of enquiry opened up the possibility of a new area of research.

The relationship between politics and the perception of mental retardation has been considered in this study, but the policies discussed have been part of the old legislative process which was deliberated behind closed doors. With the emergence of a new, more open policy, coupled with current notions of transparency among decision-makers, future researchers will have a far wider field for their exploration. It should be pointed out that a broader politically-based area of research would necessitate the need for change in the training of researchers. The implications are they will be need to be well versed in politics before embarking on their tasks.

It should also be stressed that any future researcher in the field of mental retardation will have to recognise the need to move away from the charity model of assessment, which adopted a paternalistic approach, and lean towards a more politicized model. In addition, it is suggested that further studies could profitably include an analysis of the role persons with mental handicap will play in participating in future research. In England such persons are playing increasingly important roles in this field and it is hoped that South Africa will soon follow suit.

As stated in Chapter I of this study, it was the original intention of the writer to set the beginning of this work at the date of Union in 1910. Later the decision was made to re-trace historical perceptions of lunacy to their earliest recorded origins in South Africa in order to put present-day attitudes into context. Although there were many gaps in the records, sufficient information was obtained from early accounts to enable the compilation of a composite historical background. It is felt that the coverage was extensive and that a comprehensive account was produced. However, it is suggested that collaboration between a future researcher and a political historian should facilitate the formulation of some new areas of emphasis.

This study has been confined to South Africa, with historical references and comparisons being made with conditions in nineteenth century England. It has considered how persons with mental handicap have been affected by social, political and economic change. It has been argued that mental retardation is a socially constructed condition, and the correlation between this and the industrial development of a country has been discussed. Such economic changes during recent years are not the sole prerogative of South Africa. It would be of considerable interest if similar studies were to cover other African countries, particularly those who are in the process of undergoing change.

In the absence of recorded accounts of personal perceptions of lunacy in the eighteenth and nineteenth centuries, it was decided to use literature as an illustration of changing attitudes. (Chapter II) This proved to be an area rich in material, and led into a discussion of the representation of

fictional characters with mental handicap in the film and television programmes of the present day. It was felt that to give too much emphasis to this area would have distracted from the main focus of the study, but research showed that such an approach, through literature, would offer considerable scope to the principles of documentary analysis developed in the sphere of anthropological research.

This study began by positing the question of whether, in times of economic, political or social change, persons with mental handicap are likely to be further disadvantaged. This work asserts that historically this has been found to be true. In this context "historically" refers not only to events in the distant past, but those of recent years. Future researchers may wish to explore this issue, particularly in view of the idealistic concepts voiced in the new Constitution.

Appendix to Chapter ISaamstap School.

Saamstap School (originally known as Saamstap Training Centre) was opened in 1976 in the grounds of the Midlands (Umgeni) Institute, Howick, Natal. The function of Saamstap was to provide specialised educational facilities for those children resident in the Institute considered likely to benefit from this environment. The criteria for admission was a staff assessment rather than I.Q. or psychological testing. The school was unique in Natal in that it accepted severely and profoundly retarded children, autistic children and children with severe physical handicaps in addition to their mental retardation. In short, the only children excluded were those exhibiting severe behavioural problems.

Initially the Pietermaritzburg Mental Health Society opposed the founding of the school on the grounds of expense. Their argument was that special educational facilities were already available at the Peter Pan Training Centre (later to be known as the Peter Pan School) in Pietermaritzburg, and that the children from Howick could be transported there daily. (Personal interview with Mrs. Joan Tennant, Pietermaritzburg Mental Health Society, 22nd. August 1994)

This objection was overruled on the following grounds:

- (a) Umgeni Institute had neither the financial resources, nor the available vehicles, to provide transportation for the round trip of some sixty kilometres per day.

## II

- (b) Peter Pan Training Centre was, at that time, housed in a collection of dilapidated huts overlooking a noisy freeway. The premises were grossly inadequate for the number of children already accommodated and an influx of the children from Howick would have increased the overcrowding.
- (c) Peter Pan Training Centre would not accept severely or profoundly mentally handicapped children, nor was it equipped to deal with those having severe physical handicap.

Initially Saamstap School was granted a very substantial budget by the Department of Specialised Education. It was fully staffed, well equipped and housed in pleasant premises surrounded by a garden and play area.

As financial restraints on education tightened during the late 1980s drastic staff cuts were made and further reductions anticipated. Although these would have meant increased pressure on the remaining staff, such cuts would have been willingly accepted by them if they had enabled Saamstap School to survive. (Interview with Mrs. June Hansen, former H.O.D. at Saamstap School, 12th. October 1995)

### III

At a meeting of school governors and staff called by the Department of Specialised Education in November 1992 Dr.de Preez announced the closure of the school. The argument was that the cost of maintaining a pupil at such a school was excessively high and that such money must be spent on children "who will one day have the skills to offer in the market place." No alternative scheme to allow the school to operate on a lower budget was put forward.

As mentioned previously, when Saamstap School was opened in 1976 the Department of Specialised Education stated three reasons why such an institution was perceived to be necessary. In 1992 two of these reasons were still valid. The Midlands (Umgeni) Institute was still unable to provide transport and the Peter Pan School continued to refuse admittance to profoundly or severely retarded children. The one change through the intervening years had been the translocation of Peter Pan School to excellent, purpose-built premises. This building had wheel-chair access, making the admission of non-ambulatory children possible, although, in fact, such admission was rare.

What had changed during that sixteen year period was the economic climate in South Africa. Schools for ordinary children experienced drastic budgetary cut-backs. In some cases small schools were closed and their pupils transferred to other facilities. Despite such changes these pupils were assured of a continued education. The pupils at Saamstap School were not.

#### IV

A bureaucratic decision meant that the forty-three pupils would be totally deprived of their right to special education. It was entirely due to the unceasing efforts of the staff of Saamstap School that seventeen of these pupils were accepted at Peter Pan School at the beginning of the 1993 school year.

The continuance of education for these children remains tenuous. At the present time donations from local charities assist the school in providing transport from Howick to Pietermaritzburg daily. Should such donations cease, or should the school receive further cuts in its subsidy, then education for these children will be at an end.

Appendix to Chapter IIIThe Retreat at York

In 1792 William Tuke, a wealthy tea and coffee merchant residing in York, Northern England, opened a privately funded asylum, to be known as The Retreat. A young woman, a member of his own Quaker congregation, had recently died in appalling conditions in the local asylum, and Tuke declared his intention to run his institution on the principle of moral management, a concept then regarded as revolutionary.

Samuel Tuke, grandson of the founder, describes moral management as consisting of three distinct, yet unrelated methods:

"We shall therefore inquire,

1. By what means the power of the patient to control the disorder, is strengthened and assisted.
2. What modes of coercion are employed, when restraint is absolutely necessary.
3. By what means the general comfort of the insane is promoted."

Description of the Retreat an institution near  
York for Insane Persons of the Society of Friends.

(1813 p.133)

The most important element of moral management appears to have been the cultivation of self control, whereby a patient was taught to govern his own behaviour by the practice of self-discipline.



## II

Tuke decreed that no form of physical restraint should be used in The Retreat. Patients were to be treated with kindness and respect, and by this means, Tuke argued, they would be imbued with a sense of self-respect and self-worth.

All patients were to be taught the value of personal hygiene; they were to be bathed regularly; decently dressed and well fed. The staff/patient ratio was to be high and the surroundings were to be pleasant indoors and out.

Equally innovative in 1792 was Tuke's theory that pleasant occupation was therapeutic. Wherever possible patients were encouraged to take up hobbies, particularly working in the gardens, which had the added benefit of allowing them exercise and fresh country air. (Tuke, 1813)

Tuke originally stipulated that only members of Quaker families would be accepted as patients. In view of this background it is somewhat surprising to learn that Tuke organised dances and concerts to be held in The Retreat on a regular monthly basis, as a therapeutic exercise.

It is not clear from these early references whether outsiders were admitted to these entertainments, but an interesting insight into this subject was discovered in the published diaries of Maud Berkeley, 1885 -1901, Ed.Fraser (1985)

Maud Berkeley, whose father was a retired General, had attended school in York and later paid annual visits to old schoolfriends in that city. It would appear that in the late

### III

1880s these young women, together with young men of the district, regularly organised and took part in the concerts at The Retreat. They also joined staff and patients at the monthly dances. From the Berkeley diaries it seems evident that both events were regarded as regular social occasions by the affluent citizens of York, and were well attended.

These accounts refer, of course, to events which took place some ninety years after the opening of The Retreat, but it is heartening to learn that the policies of the founder appeared to have been continued.

The first of the state institutions to adopt Tuke's policy of "non-restraint" was Hanwell Asylum, but it is not clear whether the policy of moral management was followed as closely here as it was in The Retreat.

A drawing in the Illustrated London News, 15th. January 1848 indicates that by that date Hanwell appears, to some extent, to have followed Tuke's idea of providing entertainment for the patients. Male patients, all dressed in sombre grey "uniforms" are shown dancing during their Twelfth Night Entertainment. From the caption it would appear that these events were sexually segregated, because we learn that the women patients had been given their party on New Year's Eve. It has not been possible to discover whether Hanwell Asylum had progressed, by the 1880s, to holding functions where the patients of both sexes mixed and where they wore ordinary clothes. Neither is it known whether outsiders were ever welcomed to these functions.

# APPENDIX TO CHAPTER VI

THE CUSTODY OF LUNATICS LAW, NATAL 1868

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LAW No. 1, 1868.

## Lunatics.

LAW No. 1, 1868.

(Signed) ROBT. W. KEATE.

*Law to make Provision for the Safe Custody of Persons dangerously Insane, and for the Care and Custody of Persons of Unsound Mind.*

Preamble,

WHEREAS it is expedient to make provision for the safe custody of, and the prevention of crimes being committed by, persons dangerously insane, and also for the care and maintenance of persons who are insane, but not dangerously so :

Be it therefore enacted, by the Lieutenant Governor of Natal, with the advice and consent of the Legislative Council thereof, as follows :

Resident Magistrates may commit dangerous lunatics to gaol or hospital on evidence by two medical practitioners.

1. If any person shall be discovered and apprehended under circumstances denoting derangement of mind, and a purpose of committing suicide, or having committed, or having any intention to commit any crime or offence, for which, if committed for trial, such person would be liable to be indicted, it shall be lawful for any Resident Magistrate, before whom such person may be brought, to call to his assistance any two medical practitioners (one of whom shall, if practicable, be the District Surgeon) ; and, if upon view and examination of the said person so apprehended, and upon proof upon oath by the two medical practitioners to the effect, that in their opinions such person is a dangerous lunatic, or a dangerous idiot, and, on any other proof, the said Magistrate shall be satisfied that such person is a dangerous lunatic, or a dangerous idiot, then it shall be lawful for such Magistrate, by warrant under his hand, to commit such person to some gaol or public hospital, within the said Colony, there to be kept in strict custody, until such person shall be discharged by order of one of the Judges of the Supreme Court, or shall be removed to some public lunatic asylum by order of the Lieutenant Governor for the time being, as hereinafter provided :  
Provided, every such person so detained in such gaol or public hospital, shall have the liberty and privilege of seeing his friends and legal advisers at all reasonable times.

Until discharged by order of Judge, or removed to asylum by order of Lieutenant Governor.

Provided as to access to friends and legal advisers.

Persons confined under such warrant or under criminal charges may be removed to lunatic asylum by order of Governor.

2. The Lieutenant Governor may direct, by warrant under the hand of the Colonial Secretary, that any person who may be detained in custody in any gaol or hospital, by virtue of any such warrant as aforesaid, or any person, who may be in any prison or place of confinement under any sentence of death, transportation, or imprisonment, or under any warrant on default of surety to keep the peace, or to answer any criminal charge, or in consequence of any conviction, or order of any Resident Magistrate, or under any other than civil process of the Supreme or any Circuit Court, and in respect of whom it shall be certified by two medical practitioners that such person is insane, shall be removed to such public lunatic asylum as the Lieutenant Governor shall, from time to time, appoint ; and every such person so removed, shall remain under confinement in such asylum until it shall be duly certified to the

*Lunatics.*

Lieutenant Governor, by two medical practitioners, that such person has become of sound mind; whereupon, the Lieutenant Governor is hereby authorised and required, if such person shall remain subject to be continued in custody, to issue his warrant to the keeper or other person having care of any such asylum, directing that such person be remitted to the prison or other place of confinement from which he shall have been taken; or if the period of imprisonment or custody of such person shall have expired, or if such person shall not be under any sentence of imprisonment, that such person shall be discharged.

And remain there until it shall be testified to Governor by two medical practitioners that such person has become sane.

3. If it shall be certified to the Lieutenant Governor, by two medical practitioners, that any person committed for trial for any crime or offence is insane, or an idiot, the Lieutenant Governor may, by warrant under the hand of the Colonial Secretary, order that such person shall be removed to such lunatic asylum as he shall appoint (unless in the meantime admitted to bail by some legal authority), until the Criminal Sessions of the Supreme Court, or of any Circuit Court, at which such person shall be brought to trial, or indicted according to the due course of law, and that such person shall then be remitted to the custody of the keeper or governor of the gaol, or other person, in whose custody such person may have been, under the terms of the original committal, in order to his being indicted and tried for such crime or offence, or otherwise disposed of according to law: Provided every such person, while so detained in such lunatic asylum, shall have the same liberty and privilege of seeing his friends and legal advisers at all reasonable times, which he would have had in the gaol or other prison from which he may have been removed.

Persons committed for trial, and found to be insane may be removed to lunatic asylum by order of Governor.

Until trial.  
Provided as to access to friends, &c.  
Vide Ord. 18, 1845, § 43; and Law 16, 1861, § 4.

4. In all cases in which it shall be given in evidence upon the trial of any person charged with any crime or offence, that such person was insane at the time of the commission of such crime or offence, and such person shall be acquitted, the jury shall be required to find, specially, whether such person was insane at the time of committing such crime or offence, and to declare whether such person was acquitted by them on account of such insanity, and if they shall find that such person was insane at the time of committing such offence, the Court, before whom such trial shall be had, shall order such person to be kept in strict custody in such gaol or place of confinement, and in such manner as to the Court shall seem fit, until the pleasure of the Lieutenant Governor shall be known; and the Lieutenant Governor may thereupon give such order for the safe custody of such person, in such place and in such manner as to the Lieutenant Governor shall seem fit.

When a person is acquitted on ground of insanity, the jury must state this in verdict; and the Court shall order such person to be confined until the pleasure of the Governor be known.

Governor may order safe custody of such person.

5. If it shall appear to any two medical practitioners present at an examination of any person in custody that such person is not an insane person or a dangerous idiot, and that such person may be suffered to go at large with safety, it shall be lawful for such medical practitioners, and they are hereby required, to give a certificate to that effect, signed by them, to the keeper of the asylum or gaol in which such person shall be in custody; and such keeper is hereby required to transmit the same forthwith to the Lieutenant Governor,

Any two medical practitioners present at examination may certify that the person examined is not insane;

*Lunatics.*

And Governor may order his liberation.

On application of relatives or guardian, Governor may order any lunatic to be confined.

If lunatic has no relative or guardian easily accessible, any person under whose care he is shall be deemed a guardian.

Maintenance of lunatics confined may be defrayed from public revenue.

When lunatic has sufficient means, his maintenance shall be charged upon his estate.

Visitors for lunatic asylums may be appointed by Governor.

Asylums to be visited every day.

Supreme Court, or Judge thereof, may order discharge of any sane person confined as a lunatic.

who shall thereupon order the liberation of such person from custody, unless he shall be detained therein for some other cause by due process of law.

6. The Lieutenant Governor may, on the application of one or more of the relatives or guardians of any insane person (which application shall be sanctioned in writing by one of the Judges of the Supreme Court or by a Resident Magistrate); and on receiving the certificate of two medical practitioners that they have examined and found such person to be of unsound mind, order and direct, if he think proper so to do, that such person be received into and kept in custody in such lunatic asylum as he may from time to time appoint.

7. When it shall appear to the Judge or Resident Magistrate to whom any such application shall be presented that an insane person has no relative or guardian within the Colony, or none accessible without inconvenient delay, any person or society under whose protection or care such insane person shall actually be for the time being shall, for the purposes of the preceding section, be deemed the guardian of such insane person: and it shall be lawful for such Judge or Resident Magistrate to cause the applicant, and any other person in his discretion, to be examined as to the facts in every case, on oath; and any wilfully false answer by any such applicant or person thereupon given shall be deemed perjury, and punishable as such.

8. When any insane person shall be committed to any gaol or hospital as aforesaid for the purpose of being received into such lunatic asylum as the Lieutenant Governor may appoint, the removal to and from, and the maintenance in such asylum of such insane person shall, until further provision be made therefor, be defrayed out of the Colonial revenues.

9. Provided, it shall be lawful for the keeper of any such asylum, in all cases where any lunatic or idiot shall be possessed of sufficient means to defray the expense of his maintenance in any such asylum, to agree with any relative, guardian, or friend of such lunatic or idiot for his maintenance whilst detained therein; and such relative, guardian, or friend shall be and is hereby empowered to reimburse himself all necessary sums expended in such maintenance out of any funds or property belonging to such lunatic or idiot; which funds or property are hereby made chargeable therewith.

10. The Lieutenant Governor may appoint some fit and proper person or persons, not exceeding five in number, to be the visitor or visitors of each lunatic asylum within the Colony; and may such visitor or visitors remove, and appoint another or others in his or their stead; and some one of such visitors shall be required to visit each such lunatic asylum at least once every day, unless prevented by illness or other sufficient cause; and shall from time to time make such reports to the Colonial Secretary as may be required by the order of the Lieutenant Governor.

11. If the Supreme Court, or any Judge thereof presiding at any Circuit Court or sitting in Chambers, shall receive any information upon oath, or otherwise shall have any reason or cause to suspect that any person of sound mind is confined within any lunatic

*Lunatics.*

asylum, such Court or Judge shall have full power and authority to cause the keeper of such asylum, by any warrant or order directed to such keeper, to bring such confined person before such Court or Judge for examination, at a time to be specified in such warrant or order, and if, upon the examination of such confined person, or of any medical or other witness, who may be called to testify as to the supposed sanity or insanity of such confined person, it shall appear to the satisfaction of such Court or Judge, that such confined person is of sound mind, it shall be thereupon lawful for such Court or Judge, upon the oath or affirmation of such witness, and such Court or Judge is hereby required to direct such confined person to be immediately discharged from the custody of the keeper of such asylum, unless he shall be confined therein for some other cause by due process of law.

12. If any application shall be made to the Lieutenant Governor by any relative or friend of any person still labouring under insanity, and in confinement by virtue of this Law, and such relative or friend shall be willing to undertake the charge of, and to support, such insane person, the Lieutenant Governor may, if he shall think fit, order the discharge of such insane person from such asylum: Provided no person who shall have been committed to such asylum as a dangerous lunatic, or dangerous idiot, shall be so discharged unless his friend or relative shall enter into recognisance for the peaceable behaviour of such dangerous lunatic or idiot before a Resident Magistrate, or one of the Judges of the Supreme Court: Provided, further, if it shall at any time be shown to the satisfaction of the Lieutenant Governor that any of the conditions of such recognisance shall have been broken, the Lieutenant Governor may issue a warrant directing that such dangerous lunatic or idiot shall be again confined in the asylum from which he shall have been so discharged, or such other place as to the Lieutenant Governor may seem fit.

On application of relative, Governor may order discharge of any lunatic.

Recognizance for good behaviour of dangerous lunatic must be given.

Provision for reconfinement of lunatic if recognizance broken.

13. No action shall lie against any person whatever, on account of any act, matter, or thing done or commanded by him, in carrying the provisions of this Law into effect, unless such action be commenced within three months after the cause of action or complaint shall have arisen; and if any person shall be sued on account of any act, matter, or thing, which he shall have so done, or commanded to be done, he may plead the general issue, and give the special matter in evidence.

Actions on account of things done under this Law must be raised within three months, &c.

14. All persons who may have subjected themselves to any penalty, action, or indictment, by promoting, ordering, or being in any way concerned in the care, charge, or custody of persons who may, before the time at which this Law shall take effect, have been committed to prison or put under confinement in any gaol or hospital by the authority of any Magistrate or other Judge, or of the Lieutenant Governor, as dangerous lunatics, or as having been charged with some crime or offence, shall be, and hereby are, indemnified, freed, and discharged from all penalties, actions, indictments, and liabilities which may have been incurred by reason of the confinement of such persons; and all such persons who at the

Persons concerned in confinement of lunatics previous to this Law are indemnified from liability.

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LAWS Nos. 1 & 2, 1868.

*Lunatics.—Wills and Codicils.*

Lunatics previously confined subject to provisions of this Law.

Persons who may have confined lunatics on medical certificate previous to this Law indemnified.

Interpretation clause.

"Resident Magistrate." Vide Law 6, 1859.  
"Medical Practitioner."

"Lunatic asylum."

Commencement of Law.

Short title.

date at which this Law shall take effect, shall be under such confinement, are hereby declared to be subject to the provisions of this Law, so far as the same may be applicable.

15. In all cases where any person shall, before the time at which this Law shall take effect, have been placed under restraint or confinement in any public hospital or place of confinement as insane, on the certificate or sworn testimony of a medical practitioner, given in good faith, no action or other prosecution shall lie against any person, on account of such restraint or confinement, although such confined person may have become of sound mind.

16. In this Law "Resident Magistrate" shall include the Assistant Resident Magistrate, and also associated Justices of the Peace, holding any branch court, under Law No. 6, 1859; "medical practitioner" shall mean any surgeon or physician, duly licensed to practice by virtue of any Law at any time in force in this Colony, or registered under the medical laws in force in the United Kingdom of Great Britain and Ireland, and also any medical officer of Her Majesty's land or sea forces, practising within this Colony; "lunatic asylum" shall include any hospital, or portion of any hospital, within the Colony, which may, from time to time, be appointed by the Lieutenant Governor for the custody of insane persons.

17. This Law shall take effect from the promulgation thereof in the *Government Gazette*; and may be cited as "The Custody of Lunatics Law, 1868."

Given at Government House, this 16th day of September, 1868.—

By command of His Excellency the Lieutenant Governor,

(Signed)

D. ERSKINE  
Colonial Secretary.

1882

LUNATICS (SAFE CUSTODY).

No. 20—1879.]

[Sept. 11, 1879.]

*Repealed by Act 35 of 1899* ACT

To Provide for the Safe Custody of Persons Dangerously Insane, and for the Care and Custody of Persons of Unsound Mind.

Preamble.

WHEREAS it is expedient to make provision for the safe custody of, and the prevention of crimes being committed by persons dangerously insane, and also for the care and custody of persons who are insane but not dangerously so: Be it therefore enacted by the Governor of the Cape of Good Hope, by and with the advice of the Legislative Council and House of Assembly thereof, as follows:—

How magistrates to deal with persons of unsound mind.

1. Whenever any person shall be discovered and apprehended under circumstances indicating derangement of mind, and a purpose of committing suicide, or manifesting an intention to commit any crime or offence for which, if committed for trial, such person would be liable to be indicted, it shall be lawful for any Resident Magistrate before whom such person may be brought, to call to his assistance any two duly qualified medical practitioners (one of whom shall, if practicable, be the district surgeon); and if upon view and examination of the person so apprehended, and upon proof upon oath by such two medical practitioners to the effect that in their opinion the said person is a dangerous lunatic or dangerous idiot, the said Magistrate shall be satisfied that such person is a dangerous lunatic or dangerous idiot, then it shall be lawful for such Magistrate, by warrant under his hand, to commit such person to some hospital or other place of safe confinement within this Colony, there to be kept in strict custody until such person shall be discharged by order of the Supreme Court or Eastern Districts Court, or any Circuit Court, or shall be removed to some lunatic asylum by order of the Governor, as hereinafter provided: Provided always, that every such person so detained in such hospital or other place of confinement as aforesaid, shall be allowed the privilege of being visited by his friends and legal advisers at such reasonable and convenient times as may be appointed for that purpose by the Magistrate or the superintendent of such hospital or other place of confinement.

Lunatics under commitment may be visited by their friends.

Governor may by warrant remove criminals of unsound mind to lunatic asylum.

2. The Governor may direct, by warrant under the hand of the Colonial Secretary or the Under Colonial Secretary, that any person who may be detained in any hospital or other place of confinement, by virtue of any warrant as aforesaid, or any person who may be in any prison or place of confinement under any sentence of death or imprisonment, or under any warrant of default of surety to keep the peace, or to answer any criminal charge, or in consequence of any order of any Resident Magistrate or Justice of the Peace, or under any other than civil process,



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and in respect of whom it shall be certified by two duly qualified medical practitioners that such person is insane, shall be removed to such lunatic asylum or hospital as the Governor shall appoint: And every person so removed shall remain under confinement in such asylum or hospital until it shall be certified to the Governor, upon oath or solemn declaration by two medical practitioners, that such person has become of sound mind: Whereupon the Governor shall, if such person shall remain subject to be continued in custody, issue his warrant under the hand of the Colonial or Under Colonial Secretary to the superintendent or other person having charge of any such asylum or hospital, directing that such person shall be remitted to the prison or other place of confinement from which he shall have been taken; or if the period of imprisonment or custody of such person shall have expired, or if such person shall not be under any sentence of imprisonment, or otherwise liable to be detained in custody, that such person shall be discharged.

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Such persons may be released if they become of sound mind.

3. Whenever it shall be certified to the Governor, by two duly qualified medical practitioners, that any person committed for trial, for any crime or offence, is insane, or an idiot, the Governor may, by warrant under the hand of the Colonial Secretary or Under Colonial Secretary, order that such person shall be removed to such lunatic asylum or hospital as he shall appoint, there to be detained, unless in the meantime admitted to bail by some legal authority until the criminal sessions of the Supreme or Eastern Districts Court, or any Circuit Court, at which such person shall be brought to trial, or indicted according to the due course of the law, and such person shall then be remitted to the custody of the keeper of the gaol, or other person in whose custody such person may have been under the terms of the original committal, in order to his being tried for such crime or offence, or otherwise disposed of according to law: Provided always, that every such person, while so detained in such lunatic asylum or hospital, shall have the same liberty and privilege of seeing his friends and legal advisers at all reasonable times as he would have had in the gaol or other prison from which he may have been removed.

How persons of unsound mind, under committal for trial, are to be dealt with.

4. In all cases in which it shall be given in evidence, upon the trial of any person charged with any crime or offence, that such person was insane at the time of the commission of such crime and offence, and such person shall be acquitted, the jury shall be required to find, specially, whether such person was insane at the time of committing such crime or offence, and to declare whether such person was acquitted by them on account of such insanity, and in case they shall find that such person was insane at the time of committing such offence, and shall declare that he was acquitted on that ground, the Court before which such trial shall be had shall order such person to be kept in strict custody in such gaol, lunatic

Finding of juries on trial when prisoner is of unsound mind.

How to deal with prisoner acquitted by reason of insanity.

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asylum, or other place of confinement, and in such manner as to the Court may seem fit, until the pleasure of the Governor shall be known; and the Governor may thereupon give such order for the safe custody of such person in such place and in such manner and for such time as to the Governor shall seem fit.

Persons ceasing to be dangerous lunatics.

5. If at any time after the issue of any warrant for the detention of a person as a dangerous lunatic or a dangerous idiot, under the provisions of the first section of this Act, it shall be certified to the Governor by two qualified medical practitioners that the person for whose detention such warrant was issued as aforesaid, has ceased to be or is not a dangerous lunatic or dangerous idiot, and that such person may be suffered to go at large with safety, it shall and may be lawful for the Governor by warrant under the hand of the Colonial or Under Colonial Secretary to order the liberation of such person from custody, unless he shall be detained therein for some other cause by due process of law.

Provisions for maintenance of people of unsound mind.

6. When any insane or idiotic person shall be committed to any gaol, hospital, or other place of confinement as aforesaid, for the purpose of being received into such hospital or lunatic asylum as the Governor may appoint, the removal to and from, and the maintenance in such last mentioned hospital or asylum, of such insane person shall, until further provision be made therefor, be defrayed out of the colonial revenues: Provided always, that all sums so paid may be recovered from the estate, if any, of such insane person or from any person or persons liable by law to pay for or contribute towards the maintenance of such insane person by the Civil Commissioner of the district in which such estate is situate or in which such last named persons shall reside.

Agreement may be made with curator of lunatic for his maintenance.

7. Notwithstanding the provisions of the preceding section, it shall be lawful for the keeper of any such hospital or asylum, in all cases where any lunatic or idiot confined under the provisions of this Act shall be possessed of sufficient means to defray the expense of his maintenance in any such hospital or asylum, to agree with the curator of the property of such lunatic or idiot for his maintenance whilst detained therein, and such curator shall be, and is hereby, empowered to reimburse himself all necessary sums expended in such maintenance out of any funds or property belonging to such lunatic or idiot, which funds or property are hereby made chargeable therewith.

Visitors to be appointed to lunatic asylums.

8. The Governor may appoint one or more fit and proper person or persons to be the visitor or visitors of each lunatic asylum within the Colony, and may remove any such visitor or visitors, and appoint another, or others, in his or their stead; and some one of such visitors shall be required to visit each such lunatic asylum at such times as the Governor shall direct, unless prevented by illness or other sufficient cause, and shall, from time to time, make such reports to the Colonial Secretary as may be required by the order of the Governor.

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9. If the Supreme or Eastern Districts Court, or any Judge thereof, presiding at any Circuit Court, shall receive information, upon oath, or otherwise shall have any reason or cause to suspect that any person of sound mind is confined as a lunatic or idiot within any gaol, hospital, lunatic asylum, or other place of confinement under this Act, such Court or Judge shall have full power and authority to cause the keeper or superintendent of such gaol, hospital, asylum, or other place of confinement, by any warrant or order, directed to such keeper or superintendent, to bring such confined person before such Court or Judge for examination, at a time to be specified in such warrant or order; and if, upon the examination of such confined person, or of any medical or other witness who may be called to testify as to the supposed sanity or insanity of such confined person, it shall appear to the satisfaction of such Court or Judge that such confined person is of sound mind, it shall be thereupon lawful for such Court or Judge, upon the oath, or affirmation of such witness, and such Court or Judge is hereby required to direct such confined person to be immediately discharged from custody, unless he shall be liable to be detained in custody for some other cause by due process of law.
10. If any application shall be made to the Governor by any relative or friend of any person labouring under insanity or idiocy and in confinement by virtue of this Act, and such relative or friend shall be willing to undertake the charge of and to support such insane or idiotic person, the Governor may, if he shall think fit, and if such insane or idiotic person shall not be liable to be detained in custody for any other cause by due process of law, by warrant under the hand of the Colonial or Under Colonial Secretary, order the discharge of such insane person from the gaol, hospital, lunatic asylum, or other place wherein he shall be confined: Provided that no person who shall have been committed to such gaol, hospital, or asylum as a dangerous lunatic or dangerous idiot, shall be so discharged, unless his friend or relative shall enter into sufficient recognizance for the peaceable behaviour, safe custody, and proper treatment of such dangerous lunatic or idiot before a Resident Magistrate or one of the Judges of the Supreme Court: Provided further, if it shall at any time be shown to the satisfaction of the Governor that any of the conditions of such recognizance shall have been broken, the Governor may issue a warrant under the hand of the Colonial or Under Colonial Secretary, directing that such dangerous lunatic or idiot shall be again confined in the gaol, hospital, or asylum from which he shall have been so discharged, or such other place as to the Governor may seem fit.
11. No action shall lie against any person whatever on account of any act, matter, or thing done or commanded by him in carrying the provisions of this Act into effect, unless such action be commenced within three months after the cause of action or

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Judges of supreme, eastern districts, and circuit courts may enquire into cases of alleged sanity of persons confined in lunatic asylum.

Orders to be made after enquiry.

Lunatics may be taken care of by their friends.

Recognizance to be entered into in cases of dangerous lunatics.

If recognizance broken, lunatics to be recommitted.

Limitations of actions under this Act.

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complaint shall have arisen; and if any person shall be sued on account of any act, matter, or thing which he shall have so done or commanded to be done, he may plead the general issue, and give the special matter in evidence.

Provisions of Act  
to be retrospective.

12. All persons who may have subjected themselves to any penalty, action, or indictment by promoting, ordering, or being in any way concerned in the care, charge, or custody of persons, who may, before the time at which this Act shall take effect, have been committed to prison or put under confinement in any gaol or hospital by the authority of any Magistrate or Judge, or of the Governor, as dangerous lunatics, or who having been charged with or convicted of some crime or offence, have been confined as insane persons, shall be, and hereby are, indemnified, freed, and discharged from all penalties, actions, indictments, and liabilities which may have been incurred by reason of the confinement of such persons; and all such persons who at the date at which this Act shall take effect shall be under such confinement, are hereby declared to be subject to the provisions of this Act so far as the same may be applicable.

Powers of superior  
courts not affected.

13. Nothing in this Act contained shall be construed to alter or affect the powers and authorities vested in the superior Courts of the Colony, or the mode of procedure in such Courts for declaring persons to be of unsound mind, or for the appointment of curators to the person or property of any lunatic.

Short title.

14. This Act may be cited for all purposes as the "Lunatic Law Amendment Act, 1879."

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No. 35—1891.]

[March 15, 1892.

## ACT

## To Amend the Law relating to Lunatics. (1)

Preamble.

BE it enacted by the Governor of the Cape of Good Hope, with the advice and consent of the Legislative Council and House of Assembly thereof, as follows:—

Repeal of Act No.  
20, 1879, and re-  
pugnant laws.

1. The Act No. 20, 1879, intituled "An Act to provide for the safe custody of persons dangerously insane, and for the care and custody of persons of unsound mind," and so much of any other law as may be repugnant to or inconsistent with the provisions of the Act, are hereby repealed; but this repeal shall not affect any warrant issued, or thing done in pursuance of any such repealed law.

Short title of Act.

2. This Act may be cited for all purposes as "The Lunacy Act, 1891."

Interpretation of  
terms.

3. In the construction of this Act the following terms shall have the meanings herein assigned to them unless there is something in the context repugnant to such construction:—

"Asylum" means an asylum for lunatics now existing or which may hereafter be declared by the Governor as an asylum or place for the reception or detention of lunatics.

"Court" means the Supreme Court of the Cape of Good Hope, and the Court of the Eastern Districts, the High Court of Griqualand, and any Circuit Court, within the limits of the jurisdiction of such Courts respectively.

"Criminal Lunatic" means any person for whose safe custody during the Governor's pleasure, the Governor is authorised to give order, and any prisoner whom the Governor has in pursuance of this or any other law directed to be removed to an asylum or other place for the reception of insane persons.

"Judge" Any judge of the Supreme Court.

"Constable" includes members of the police force, and field-cornets.

"Lunatic" includes any idiot or person of unsound mind incapable of managing himself or his affairs.

"Magistrate" means a resident magistrate, and includes an acting resident magistrate and an assistant magistrate.

"Medical Practitioner" means a legally qualified medical practitioner, in actual practice, within the meaning of any law now or hereafter in force.

"Prison" means any prison or place of confinement to which a person may be committed, whether on remand or for trial, safe custody, punishment or otherwise, under any other than civil process; and

"Prisoner" means any person so committed.

<sup>1</sup> Extended by Proclamation No. 69 of 1892 to all the Native Territories, and by Proclamation No. 340 of 1894 to East and West Pondoland.

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4. The provisions of this Act shall apply to every person who, at the taking effect thereof, is detained in an asylum or place of confinement for lunatics, and every warrant or order granted for the detention of any such person, shall be deemed to have been legally granted until set aside or varied under the provisions of this Act.

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Act to apply to persons detained in asylum at time of taking effect thereof.

5. If a constable is satisfied that it is necessary for the public safety or the welfare of an alleged lunatic with regard to whom it is his duty to take any proceedings under this Act, that the alleged lunatic should, before any such proceedings are taken, be placed under care and control, the constable may apprehend and convey the alleged lunatic to a prison or hospital, and the gaoler or keeper of the hospital shall, unless there is no proper accommodation in such prison or hospital for the alleged lunatic, receive, relieve and detain the alleged lunatic therein, but no person shall be so detained for more than forty-eight hours without the knowledge or authority of a Magistrate.

Constable may under certain circumstances remove alleged lunatic to prison or hospital.

## PART I.

## PROCEEDINGS FOR RESTRAINING DANGEROUS LUNATICS.

6. When any person shall be discovered under circumstances indicating derangement of mind, and a purpose of committing suicide, or some crime or offence for which such person would be liable to be prosecuted, any Magistrate before whom such person shall be brought, may call to his assistance any two medical practitioners (one of whom shall if practicable be the District Surgeon) and shall examine such practitioners and any other witnesses upon oath.

Proceedings to be taken by Magistrate if supposed dangerous lunatic brought before him.

7. If on view and examination of the person apprehended or brought before the Magistrate, and on the evidence of such medical practitioners and others, the Magistrate is satisfied that such person is a dangerous lunatic, and that his case cannot be adequately dealt with under the provisions of Part III of this Act, then he may by order under his hand direct that such person shall be removed to and detained in some hospital or other place of safe confinement, until such person shall be lawfully discharged, or removed to some asylum by order of the Governor.

Proceedings if Magistrate is satisfied that person is a dangerous lunatic.

8. Any Magistrate or Justice of the Peace, upon its being made to appear to him on oath, that any person wandering at large is deemed to be a dangerous lunatic, may, by order under his hand require any constable to apprehend and bring such person before any Magistrate having jurisdiction.

Magistrate or J.P. may issue order to apprehend person deemed to be dangerous lunatic and wandering at large.

9. Any constable receiving any order from a Magistrate or Justice of the Peace, shall forthwith act as therein directed, either in apprehending or removing such lunatic or supposed lunatic therein named. And any person who may by any order of a Magistrate be directed to receive and detain any such lunatic or supposed lunatic, shall act in obedience to such order.

Constable to obey such order.

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Governor may order discharge of person so apprehended if it appears he is not a dangerous lunatic.

10. If at any time after the granting of any order or warrant for the detention of a person as a dangerous lunatic, it shall be made to appear to the Governor that such person has ceased to be, or is not a dangerous lunatic, and that he may be suffered to go at large with safety, the Governor may order the discharge of such person from custody, unless he be lawfully detained for some other cause.

Sections 29 to 36 to apply to orders for the detention of dangerous lunatics.

11. The provisions of the twenty-ninth to the thirty-sixth sections, inclusive, of this Act, shall respectively extend and apply to every order for the detention of a dangerous lunatic granted by any Magistrate in pursuance of this part of this Act.

## PART II.

### PROVISIONS RELATING TO CRIMINAL LUNATICS.

Procedure where persons charged with offences are found to be insane by a jury.

12. When in any indictment or other criminal process any act or omission is charged against any person as an offence, and it is given in evidence on the trial of such person for that offence that he was insane, so as not to be responsible according to law for his actions at the time when the act was done or the omission made, then if it appears to the jury before whom, or the court (where there is no jury) before which such person is tried, that he did the act or made the omission charged, but was insane as aforesaid at the time when he did or made the same, the jury of such court shall return a special verdict or finding to the effect that the accused was guilty of the act or omission charged against him, but was insane as aforesaid at the time when he did the act or made the omission.

Such persons to be kept in custody as criminal lunatics.

13. Whenever such special verdict or finding shall be returned, the presiding judge or court shall order the accused to be kept in custody as a criminal lunatic in such place and in such manner as the court shall direct till the Governor's pleasure shall be known; and it shall be lawful for the Governor thereupon, and from time to time, to give such order for the safe custody of the said person in such place and in such manner as to the Governor may seem fit.

Prisoners not under sentence of death who may appear insane, to be examined by two medical men by order of Colonial Secretary or a Magistrate.

14. Where it appears to the Colonial Secretary or a Magistrate that a prisoner, not being under sentence of death, is insane, such Secretary or Magistrate shall direct two medical practitioners (one of whom shall, if practicable, be the district surgeon) to examine such person and inquire as to his sanity, and after such examination and inquiry the said medical practitioners may certify, in writing, that he is insane.

If under sentence of death to be examined by two or more medical men by order of Governor.

15. In the case of a prisoner under sentence of death, if it shall be made to appear to the Governor that there is reason to believe such prisoner to be insane, the Governor may appoint two or more medical practitioners, who shall forthwith examine such prisoner and inquire as to his insanity, and after such examination and inquiry such practitioners shall make a report, in writing, to the Governor as to the sanity of the prisoner, and they, or the majority of them, may certify that he is insane.

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16. When a prisoner is certified as aforesaid to be insane the Governor may, if he thinks fit, direct such prisoner to be removed to an asylum named in the warrant, and thereupon such prisoner shall be removed to and received in such asylum, and subject to the provisions of this Act relating to discharge and otherwise, shall be detained therein, or in any other asylum to which he may be transferred, as a criminal lunatic, until he ceases to be a criminal lunatic.

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If prisoner certified insane, to be removed under warrant of Governor to some asylum and detained there as a criminal lunatic.

17. When it is certified by two medical practitioners that a person being a criminal lunatic (not being a person with respect to whom a special finding or verdict, has been returned that he was guilty of the act or omission charged against him, but was insane at the time when he committed the act or made the omission) is sane, the Colonial Secretary if satisfied that it is proper to do so, may by warrant direct such person to be remitted to prison, to be dealt with according to law.

When it is certified that a criminal lunatic (other than one in respect to whom a special verdict was returned) is sane, the Colonial Secretary may order him to be remitted to prison.

18. The superintendent of an asylum or other place in which a criminal lunatic is detained, shall make a report to the Colonial Secretary at such times (not being less than once a year), and containing such particulars as the Colonial Secretary may require, of the condition and circumstances of every criminal lunatic in such asylum or place; and the Colonial Secretary shall at least once in every two years during which a criminal lunatic is detained, take into consideration the condition, history, and circumstances of such lunatic, for the purpose of determining whether he ought to be discharged or otherwise dealt with.

Superintendent of asylum or other place in which criminal lunatic is detained, to report to Colonial Secretary at least once a year.

19. The Colonial Secretary may, from time to time, order the transfer to an asylum of any criminal lunatic detained in any other asylum or in any other place, and such criminal lunatic shall accordingly be received and detained in the asylum to which he is so transferred.

Colonial Secretary may order transfer of criminal lunatic.

20. The Governor may discharge any criminal lunatic absolutely, or conditionally, that is to say, on such conditions as to the duration of such discharge, and otherwise as the Governor may think fit.

Governor may discharge criminal lunatic, absolutely or conditionally.

21. Where a criminal lunatic is conditionally discharged in pursuance of this Act:

Conditions to be observed in conditional discharge.

- (1) A report of his condition shall be made to the Colonial Secretary by such person and at such times and containing such particulars as may be required by the warrant of discharge, or directed by the Governor, or by any general rules and regulations;
- (2) If any of the conditions of such discharge appear to the Governor to be broken, or the conditional discharge is revoked, the Governor may direct him to be taken into custody, and removed to some asylum or place named in the warrant; and he may thereupon be taken, and shall be received and detained in such asylum or place as if he had been removed thereto under the provisions of this Act.



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Governor may make regulations for dealing with prisoners who appear from imbecility to be unfit for penal discipline.

22. The Governor may make, revoke, and vary regulations for the treatment of persons sentenced to imprisonment who appear, in accordance with the said regulations, to be from imbecility of mind, either unfit for penal discipline, or unfit for the same penal discipline as other prisoners.

### PART III.

#### PROVISIONS RELATING TO LUNATICS NOT BEING DANGEROUS NOR CRIMINAL.

Magistrate may order apprehension of person wandering at large and deemed to be a lunatic but not criminal nor dangerous.

23. Any Magistrate, upon the information on oath of any person, that a person wandering at large is deemed to be a lunatic, may by order require a constable to apprehend the alleged lunatic and bring him before the Magistrate making the order, or before any Magistrate having jurisdiction where the alleged lunatic is.

Magistrate may examine such person

24. When under this Act notice has been given to, or an information on oath laid before a Magistrate, that a person wandering at large is deemed to be a lunatic, such Magistrate may examine the alleged lunatic at his own house, or elsewhere, and may proceed in all respects as if the alleged lunatic had been brought before him.

Constables to report to Magistrate cases of lunatics not under proper care, though not wandering abroad.

25. Every constable who has knowledge that any person not wandering at large is deemed to be a lunatic and is not under proper care and control, or is cruelly treated, or neglected by any relative or other person having the care or charge of him shall without delay give information thereof on oath before the nearest Magistrate.

Upon information of cases under Section 25, Magistrate may order person to be examined by medical practitioner.

26. Upon the affidavit or information on oath of any person that a person is deemed to be a lunatic, or that such a person is not under proper care, treatment and control, or is cruelly treated or neglected as aforesaid, any Magistrate may himself, visit the alleged lunatic, and shall, whether making such visit or not, direct and authorise any two medical practitioners whom he thinks fit (one of whom shall, if practicable, be the District Surgeon) to visit and examine the alleged lunatic, and to report their opinion of his mental state. In case the services of two medical practitioners shall not be available, or immediately available, the Magistrate may direct one medical practitioner to perform such duty.

"Summary Reception Order."  
If Magistrate satisfied that person is lunatic and not under proper care, he may order person to be detained.

27. If upon the report of the medical practitioners or practitioner who examined the alleged lunatic, or after such further or other enquiry as the Magistrate thinks necessary, he is satisfied that the alleged lunatic is a lunatic, and is not under proper care, treatment and control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, and that he is a proper person to be taken charge of and detained under care and treatment, or if the person having the care, treatment or control of the alleged lunatic consents to the issue of the order hereinafter mentioned, the Magistrate may by order (in this Act termed a Summary Reception order) direct the lunatic to be received and detained in some asylum or other place to be named in such order,

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and any constable whom the Magistrate may require so to do shall forthwith convey the lunatic to the place named in the order. No. 35 - 1891.

28. A summary reception order shall authorise the detention of the person named therein for a period not exceeding one month. Such order shall authorise detention for one month.

29. A Magistrate granting any order for the detention of any alleged lunatic under this Act shall, without delay, transmit a copy thereof with copies of the depositions and medical reports upon which he acted in granting such order, and his own report to the Attorney-General, or in case the lunatic shall be within the districts over which the Court of the Eastern Districts, or the High Court of Griqualand respectively have jurisdiction, to the Solicitor-General, or Crown Prosecutor as the case may be. The Magistrate shall also within ten days transmit as aforesaid the report of the District Surgeon or such medical practitioner as shall have been in attendance upon the lunatic, as to his mental and bodily condition during his detention. Such Magistrate shall also make such report (if any) to the Colonial Secretary as may be prescribed by any general regulations, and otherwise conform thereto. Magistrate granting such order to send copy of order, report and medical practitioner's report, to the Attorney-General, Solicitor-General or Crown Prosecutor.

30. In the case of a lunatic as to whom a summary reception order may be made, nothing in this Act shall prevent a relative or friend from retaining or taking the lunatic under his own care, if the Magistrate having jurisdiction to make the order shall be satisfied that proper care will be taken of the lunatic. Provido as to lunatics being taken charge of by relatives or friends.

31. The Attorney-General, and the Solicitor-General and Crown Prosecutor, of Griqualand West, within the limits of the districts respectively in which the latter exercise their functions, shall be *ex officio curators ad litem* of such persons as may be detained under any order granted by a Magistrate under this Act, or further detained under a Judge's order. The Attorney-General, Solicitor-General and Crown Prosecutor *ex officio* curators ad litem of such lunatics within their jurisdictions.

32. A *curator ad litem* receiving any such order, depositions and reports as aforesaid from a Magistrate, shall, within the said period of one month, lay the same with any further reports, depositions, or statements which he may have deemed necessary to call for, before a Judge in chambers for his consideration. *Curator ad litem* receiving above reports, &c., to lay the same before Judge in chambers.

33. The Judge upon consideration of such order, reports and evidence of lunacy therein appearing, may order as follows:— The Judge may:—

- (1) If satisfied that an order for the further detention of the alleged lunatic may be made forthwith, make such order accordingly, and for such period as he may deem necessary. Order further detention of alleged lunatic.
- (2) Direct that a summons be issued and served upon the alleged lunatic and the *curator ad litem*, to appear in the court to be therein named to show cause why the alleged lunatic shall not be declared lunatic, and a curator appointed for the care of his person, and if necessary, for the care or administration of his property. Call upon *curator ad litem* and lunatic to appear before an appointed court.
- (3) Appoint a *curator bonis* for the temporary care or custody of any property of the alleged lunatic, and where it appears Appoint *curator bonis*.

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to the Judge desirable that temporary provision should be made for the maintenance or other necessary purposes or requirements of the alleged lunatic, or any member of his family out of any cash, or available securities belonging to him in the hands of his bankers or of any other person. the Judge may authorise any such banker or other person to pay to the *curator bonis* such sums as may be deemed necessary, and may give directions as to the application thereof for the alleged lunatic's benefit, or the relief of his family.

Direct discharge  
of alleged lunatic.  
Direct as to issue  
service, &c., of sum-  
mons.

- (4) Direct that the alleged lunatic be immediately discharged.  
(5) Direct that any summons or other process be issued, and the proceedings in the case be continued, free of any stamp duty or office fee; and order that service of any process under this section be made in such manner as may seem expedient.  
(6) Generally give such directions as may appear necessary and proper.

Generally give  
necessary directions.

Husband, wife  
friend or relative of  
person deemed to be  
lunatic may apply  
directly to any court  
or judge for enquiry.

34. Nothing in this Act contained shall prevent any husband, wife, or other relative of any person deemed to be a lunatic, or any friend of such person who has no husband, wife, or near relative at or near the place where such person is residing from applying by petition directly to any court or judge for an enquiry into such person's mental condition, whether a summary reception order shall previously have been granted or not, and such court or judge may order therein as may be deemed fitting.

Any person de-  
tained under a sum-  
mary reception order  
may apply to court  
for an enquiry.

35. Any person detained under the order of a Magistrate under this Act, or under a Judge's order for further detention, granted as aforesaid, may apply to the court, directly or through a *curator ad litem*, for an enquiry into the cause and grounds of such person's detention, and such court may order therein as may be deemed fitting.

Where a person is  
ordered to be further  
detained or is de-  
clared a lunatic, the  
Under Colonial Sec-  
retary may order his  
removal to asylum.

36. When any Judge has granted an order for the further detention of a lunatic, or when a court has declared a person lunatic, the Under Colonial Secretary may by warrant under his hand authorise the removal of such lunatic to some asylum, hospital, or other safe place of confinement, there to be detained until legally discharged or legally removed to some other asylum or place.

## PART IV.

## PROVISIONS FOR THE CARE AND ADMINISTRATION OF LUNATIC'S PROPERTY.

Court may appoint  
curator over pro-  
perty of lunatic.

37. The court may appoint a curator for the care or administration of the property of any person declared lunatic, or of a person lawfully detained as a criminal lunatic or dangerous lunatic, with or without security, as the court may direct, and may confer upon such curator authority to do any specified act, or exercise any specified power, or may confer a general authority to exercise on

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behalf of the lunatic, until further order, all or any of such powers without further application to the court.

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38. Where upon an enquiry the court shall be of opinion that the person to whom it relates is of unsound mind so as to be incapable of managing his affairs, but that he is capable of managing himself, and is not dangerous to himself or to others, such court may make such order as it thinks fit for the care or administration of the property of the lunatic, including all proper provisions for his maintenance, but it shall not be necessary, unless the court shall think proper to do so, to make any order as to the custody of his person.

Court may under certain circumstances appoint curator over property without appointing curator over person.

39. When any person being a member of a partnership is declared a lunatic by the court, the court may by the same order, or by any order subsequently granted, dissolve the partnership.

Court may dissolve a partnership if member thereof declared a lunatic.

40. When a court has granted an order for appointing a curator for the care or administration of the property of a lunatic, an office copy of such order shall forthwith be lodged with the Master of the Supreme Court.

Copy of order appointing curator over property, to be lodged with Master.

41. The Master shall grant to such curator a certificate that he has been so appointed, and is authorised as such to have the custody and administration of the lunatic's estate.

Master to grant certificate of appointment to curator.

42. Every such curator shall be under the like duty and obligation as an executor appointed for the administration of the estate of a deceased person, to lodge with the said Master an inventory, or additional inventory of the property of a lunatic and accounts of his administration, and in respect of any such inventory or account the like stamps and fees shall be payable as in the case of the estate of a deceased person.

Curator to file inventory, &c., with Master.

43. Every such curator shall be allowed the like remuneration, to be taxed by the said Master, as in the case of an executor.

Curator to be allowed same remuneration as executor.

44. When any lunatic for the care or administration of whose estate a curator has been appointed shall die intestate, or having left a will there shall be no executor, or none willing to act, such curator shall continue the administration of the estate of such lunatic, and distribute the assets thereof as if he had been appointed an executor *dativo*.

If lunatic dies intestate, or has no executor, curator bonis to act as executor.

45. The court may authorise and direct any curator appointed as aforesaid to do all or any of the following things:—

Court may authorise curator to do following Acts.

- (1) Sell any property belonging to the lunatic.
- (2) Make exchange or partition of any property belonging to the lunatic, or in which he is interested, and give or receive any money for equality of exchange or partition.
- (3) Carry on or discontinue any trade or business of the lunatic.
- (4) Grant leases of any property of the lunatic.
- (5) Perform any contract relating to the property of the lunatic entered into by the lunatic before his lunacy.
- (6) Exercise any power or give any consent required for the exercise of any power where the power is vested in the

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lunatic for his own benefit, or the power is in the nature of a beneficial interest in the lunatic.

(7) Raise money on mortgage of the lunatic's property for payment of his debts, or payment of any debt or expenditure incurred for the lunatic's maintenance or otherwise for his benefit, or payment of, or provision for, the expenses of his future maintenance.

(8) Apply any money for or towards the maintenance or the benefit of the lunatic.

(9) Make such reports concerning the lunatic's estate to the court or to the Master as such court shall deem fit.

Act not to be taken to limit power of Court as to declaring persons insane, or appointing curators.

46. Nothing in this Act contained shall be deemed to limit or abridge the power by law possessed by the court in regard to declaring persons of unsound mind, or to the appointment of curators to the person or property of any lunatic.

PART V.

OFFENCES AND PENALTIES.

Penalty for detaining alleged lunatic except under provisions of this Act.

47. Every person who, except under the provisions of this Act, receives or detains a lunatic, or alleged lunatic in an asylum, or for payment takes charge of, receives to board and lodge, or detains a lunatic or alleged lunatic, shall, upon conviction, be liable to a penalty of fifty pounds.

Penalties for false statements, &c.

48. Every person guilty of any of the following acts or offences shall, upon conviction, be liable to a penalty not exceeding one hundred pounds, or to imprisonment, with or without hard labour, for any period not exceeding twelve months:

- (1) Making any wilful misstatement of any material fact in any petition, application, statement of particulars, report, or reception order under this Act.
- (2) Making a wilful misstatement of any material fact in any medical certificate, or other certificate, or in any statement or report of bodily or mental condition under this Act.
- (3) Knowingly making in any book, statement, or return, any false entry as to any matter as to which he is by this Act or by any rules or regulations made under this Act, required to make an entry.
- (4) Wilfully obstructing any magistrate, curator, curator *ad litem*, visitor, medical practitioner, constable, or other person specially authorised by the Governor, or under any order of court, in the exercise of any of the powers conferred by this Act, or by any rules or regulations made under this Act.

Penalty where no special penalty provided.

49. Every person who shall contravene any of the provisions of this Act in respect of which no other penalty or punishment is by this Act or by any law otherwise provided, or who shall contravene any of the provisions of any rules or regulations made by the

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Governor under this Act, shall, upon conviction, be liable to a penalty not exceeding twenty pounds.

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50. Any officer, nurse, attendant, servant, or other person employed in any asylum or other place, or any person having the care or charge of a lunatic, or alleged lunatic, whether by reason of any contract, or any tie of relationship, or marriage, or otherwise, who shall illtreat or wilfully neglect any such lunatic or alleged lunatic shall, upon conviction, be liable to a penalty not exceeding fifty pounds, or to imprisonment, with or without hard labour, for any period not exceeding six months.

Penalty if nurses, &c., or persons in charge illtreat lunatic.

51. Any officer, attendant, servant, or other person employed in any asylum or other place, who shall wilfully permit, or assist, or connive at the escape or attempted escape of any lunatic, or secretes a lunatic shall, upon conviction, be liable to a penalty not exceeding twenty pounds, and to instant dismissal from any position such convicted person may then occupy.

Penalty for conniving at escape of lunatic.

52. It shall not be lawful to employ any male person in any asylum in the personal custody or restraint of any female patient, and any person employing a male person contrary to this section shall be liable to a penalty not exceeding twenty pounds: Provided that this section shall not extend to prohibit or impose a penalty on the employment of male persons on such occasions of urgency as may in the judgment of the superintendent of the institution render such employment necessary, but the employment shall be reported to the Colonial Secretary.

Male persons not to be employed in personal custody of female patient.

Proviso.

53. If any officer, attendant, or any other person employed in any asylum, or any person having the care or charge of or attending upon any single patient, carnally knows, or attempts to have carnal knowledge of any female under care or treatment as a lunatic, he shall, upon conviction, be liable to imprisonment with or without hard labour for any period not exceeding five years; and no consent or alleged consent of such female thereto shall be a defence in any prosecution for such offence.

Penalty on person having charge of lunatic, for carnally knowing female patient.

PART VI.

MISCELLANEOUS PROVISIONS.

54. Subject to any exception in this Act mentioned, a person not being a dangerous lunatic, a criminal lunatic, or a lunatic so declared by a Court, shall not be received or detained in any asylum, hospital or other place, or as a single patient, unless under an order made by a Court or Judge.

No person to be detained in asylum who is not a criminal, dangerous or declared lunatic, unless under order of Court or Judge.

55. Every person who shall receive to board and lodge in his house, or shall take care or charge for payment or valuable consideration of any person as a lunatic shall, within twenty-four hours after so receiving or taking such person, transmit through the post a notice of such admission to the Colonial Secretary with

Every person receiving a patient into his house to transmit a notice thereof to the Colonial Secretary.

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Also a report of patient's mental state, &c., signed by medical attendant.

Every such patient to be visited by independent medical practitioner.

Notice to Colonial Secretary if patient detained for more than 3 months in private house without an order under Act.

Colonial Secretary may order enquiry as to lunatics detained in any private house.

Requirements of medical certificates under Act.

Medical certificate evidence of certain facts.

Medical certificates not to be signed by person related to

true copies of the order, statement and medical certificates upon which such person shall have been so received.

56. The person so receiving or taking charge of such lunatic shall also, after the second, and before the end of the tenth day from such admission, transmit to the Colonial Secretary a statement to be signed by the medical practitioner visiting the lunatic, of his mental state, and his bodily health and condition.

57. Every such, lunatic shall, as often as may be provided by regulations under this Act, or as may be directed by the Colonial Secretary, be visited by a medical practitioner not deriving, and not having a partner, father, son, brother or other relative who derives any profit from the care and charge of such lunatic.

58. If any occupier or inmate of any house shall keep or detain therein any person as a lunatic, except under some order authorised by this Act, although one of his family or a relative, beyond the period of three months after his lunacy shall have become apparent, and when it shall be such as to require during any part of such period coercion or restraint, such occupier or inmate, or the medical practitioner attending such person, shall intimate such detention to the Colonial Secretary, and shall transmit to the Colonial Secretary a certificate signed by at least one medical practitioner of the condition of the person so detained, and shall state therein the reasons (if any) which render it desirable that such person shall remain under private care.

59. If the Colonial Secretary shall have information or reason to believe or suspect that any lunatic, or any person treated as a lunatic, of whose condition no such intimation as aforesaid has been made is detained or kept, or is dwelling in any house, and that the lunacy of such person has endured for three months after the same became apparent, and is such as to have required coercion or restraint, or if such intimation shall have been made as in the last section provided, and the reason stated appear to be insufficient, and he is of opinion that enquiry should be made, he may order such enquiry to be made as he shall think fit.

60. Every medical certificate or report under this Act shall be signed by a medical practitioner, and shall state the facts upon which the certifying medical practitioner has formed his opinion that the alleged lunatic is a lunatic, distinguishing facts observed by himself from facts communicated by others; and no order made under this Act shall be made upon a certificate founded only upon facts communicated by others.

61. Every medical certificate or report made under, and for purposes of this Act, shall be evidence of the facts therein appearing so far as they may be facts within the knowledge of the person making the certificate, and of the judgment therein stated to have been formed by the certifying medical practitioners on such facts, as if the matters therein appearing had been verified on oath.

62. The medical certificates or reports under this Act shall not be received or acted upon if made by any person related to the

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supposed lunatic within the fourth degree of consanguinity or affinity, or the partner or assistant of a person so related; and neither of the persons signing such certificates or reports shall be so related to, or the partner or the assistant of, the other of them. No. 35—1891.  
alleged lunatic with-  
in fourth degree.

63. Mechanical means of bodily restraint shall not be applied to any lunatic unless the restraint is necessary for the purposes of surgical or medical treatment, or to prevent the lunatic from injuring himself or others; and in every such case:

- (1) A medical certificate shall, as soon as it can be obtained, be signed, describing the mechanical means used, and stating the grounds upon which the certificate is founded. Under what cir-  
cumstances mechan-  
ical means of bodily  
restraint allowed.
- (2) The certificate shall be signed, in the case of a lunatic in an asylum or other place of confinement, by the medical officer thereof, and in the case of a private patient, by his medical attendant.
- (3) A full record of every case of restraint by mechanical means shall be kept from day to day.
- (4) A copy of the certificates and records under this section shall be sent to the Colonial Secretary at the end of every quarter.
- (5) In the application of this section "mechanical means" shall be such instruments as the Governor may, by regulations, determine.

64. Any magistrate, or any commissioner, or person appointed by any competent court, or by the Governor, to make any enquiry under this Act, or in respect of any lunatic, may, if he deems it necessary so to do, summon any person to appear before him to testify on oath touching any matter respecting which such magistrate, commissioner or other person is under this Act, or by any commission or order issued by any such court, or by the Governor, authorised to enquire (which oath such magistrate, commissioner or other person is hereby empowered to administer). Any person ap-  
pointed under this  
Act to make enquiry  
may examine on oath  
and summon wit-  
nesses.

65. Every person who does not appear pursuant to any such summons as is in the last section mentioned, or does not assign some reasonable excuse for not appearing, or who appears and refuses to be sworn or examined, shall, on conviction in the court of any Resident Magistrate having jurisdiction, be liable to a penalty not exceeding twenty pounds. Penalty for not  
obeying such sum-  
mons.

66. Every person so summoned as aforesaid shall be entitled to be paid his expenses as if a witness summoned to attend upon a trial in a criminal case. Expenses of wit-  
nesses.

67. A warrant of the Governor under this Act may be under the hand of the Colonial Secretary or of the Under Colonial Secretary, and where any warrant is authorised or required to be granted by the Colonial Secretary, such warrant may be under the hand of the Under Colonial Secretary. Every such warrant may be executed by the person to whom it is addressed or by any constable, and when it relates to a person not in custody may be

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Powers of Colonial Secretary under Act may be exercised by another person appointed by Governor.

Escaped lunatic may be recaptured.

Action by lunatic limitation of.

Governor may make, &c., regulations.

executed in like manner as if it were a warrant for the arrest of a person charged with an offence, and it shall be the duty of every constable to aid in the execution of every warrant under this Act.

68. The Governor may, from time to time, direct that all or any of the powers, duties and authorities by this Act vested in or required to be performed by the Colonial Secretary, shall be exercised and performed by any person the Governor shall think fit, subject to any restrictions or limitations he may impose, or that such powers, duties, and authorities may, as to certain parts of the Colony, be exercised by the Colonial Secretary, and as to certain other parts by some person or persons other than the Colonial Secretary.

69. If any person escapes while being conveyed to an asylum or place in pursuance of this Act, or if any person lawfully detained in an asylum or other place for lunatics escapes, he may be retaken by the superintendent of such asylum, or any officer or servant belonging thereto, or by any person assisting such superintendent, officer or servant, or by any constable, and conveyed to and received and detained in such asylum.

70. Any action brought by any person who has been detained as a lunatic against any person for anything done under this Act shall be commenced within three months next after the release of the person bringing the action.

71. The Governor may, from time to time, make and alter rules or regulations for all or any of the following purposes :—

- (1) For the discharge of lunatics on the application of relatives or friends, or on probation.
- (2) For the removal or transfer of lunatics from one asylum or place to another asylum or place.
- (3) For the guidance of visitors and as to the reports to be made to or by them.
- (4) For prescribing the books to be kept in asylums or otherwise in reference to any lunatic, and the entries to be made therein, and the accounts, returns, reports, extracts, copies, statements, notices, documents and information to be sent to the Colonial Secretary, or other authority or person as the Governor may direct.
- (5) As to the persons by whom, the times when, and the manner in which such entries, accounts, returns, reports, extracts, copies, statements, notices, documents and information are to be made and sent, in regard to any asylum, or any lunatic or alleged lunatic.
- (6) As to the terms of payment and accommodation for paying patients in any asylum.
- (7) For prescribing forms for the purposes of this Act, in addition to, or in substitution for, any forms mentioned in the Schedule.
- (8) Generally for the due administration and efficient working of this Act, and the care and comfort of lunatics.

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72. Subject to rules made under this Act the forms in the Schedule may be used, wherever applicable, with such modifications as circumstances may require, and if used shall be deemed to be sufficient.

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Forms in Schedule may be used.

SCHEDULE.

FORMS FOR USE UNDER "THE LUNACY ACT, 1891."

No. 1.—Order for the reception of a Lunatic.

I, A. B., Resident Magistrate for the District of \_\_\_\_\_, having called to my assistance B. C., and D. E., medical practitioners, and having personally examined F. G., of \_\_\_\_\_, and being satisfied that the said F. G. is a dangerous lunatic, hereby direct you, H. I., keeper of the \_\_\_\_\_ hospital (or other place to be stated) to receive the said F. G. as a patient in the said hospital (or other place) and detain him until he shall be lawfully discharged or removed.

Section 7.

Given under my hand at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_.

Resident Magistrate.

To H. I.

Keeper of the \_\_\_\_\_ hospital  
(or other description).

No. 2.—Order for the apprehension of a Lunatic wandering at large.

Whereas it has been made to appear to me, \_\_\_\_\_, Resident Magistrate of the District of \_\_\_\_\_, by information upon oath, that \_\_\_\_\_ a person wandering at large within the said District, is deemed to be a dangerous lunatic (or a lunatic—*Vide* Section 23). Now, therefore, these are to require you to apprehend the said \_\_\_\_\_ and bring him before me (or before the Resident Magistrate of \_\_\_\_\_).

Sections 8 and 23.

Given under my hand at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_.

Resident Magistrate.

To

Constable (or otherwise as the case may be).

NOTE.—In the case of a dangerous lunatic this order may be granted by a justice of the peace, and the form may be altered accordingly.

No. 3. Medical Certificate that a person is a Lunatic.

I, the undersigned, \_\_\_\_\_, being a duly licensed medical practitioner in this Colony, and in actual practice, hereby certify that I, on the \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_, at \_\_\_\_\_, in \_\_\_\_\_, separately from any other medical practitioner, personally examined \_\_\_\_\_ of \_\_\_\_\_, and that the said \_\_\_\_\_ is a person of unsound mind, and a proper person to be taken charge of and detained under care and treatment, and that I have formed this opinion upon the following grounds, viz.:—  
1st. Facts indicating insanity or idiocy observed by myself.  
2nd. Facts indicating insanity or idiocy communicated to me by others.

Sections 14, 15, 17, 28.

1. Appearance.

2. Conduct.

3. Conversation.

4. State the information, and from whom.

(Signed) \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 18 \_\_\_\_\_, at \_\_\_\_\_.

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R 6918/94

## WET N<sup>o</sup>. 9, 1894,

OM VOORZIENING TE MAKEN VOOR DE VEILIGE BEWARING  
VAN GEVAARLIJKE KRANKZINNIGEN EN VOOR DE ZORG  
EN DE BEWARING VAN PERSONEN VAN GEKRENKTE  
GEESTVERMOGENS.

*Goedgekeurd door den Edel Achtbaren Tweeden Volksraad, bij art.  
529, dd. 3 Juli 1894, en door den Edel Achtbaren Eersten  
Volksraad onder art. 818, dd. 12 Juli daaropvolgende voor-  
loopig voor kennisgeving aangenomen.*

ART. 1. Voor de doeleinden dezer wet zullen de volgende uitdrukkingen de hierin aan hen toegekende beteekenis hebben, tenzij er iets in den samenhang strijdig met zoodanige verklaring is:

“Gesticht” beteekent het nu bestaande Krankzinnigengesticht, of eenige inrichting die later door de Regeering verklaard moge worden een gesticht of plaats te zijn voor de ontvangst of aanhouding van krankzinnigen.

“Hof” beteekent het Hooggerechtshof, en eenig Rondgaand Hof.

“Misdadige Krankzinnige” beteekent eenige persoon voor wiens veilige bewaring, zoolang de Staatsprocureur zal noodig cordeelen, deze gemachtigd is last te geven, en iedere gevangene die de Uitvoerende Raad of de Staatsprocureur krachtens deze of eenige andere wet heeft gelast te worden vervoerd naar een gesticht of andere plaats voor de ontvangst van krankzinnigen.

“Rechter” eenig Rechter van het Hooggerechtshof.

“Konstabel” sluit in leden van de politiemacht.

“Krankzinnige” sluit in iedere idioot of persoon gekrenkt van hersenen die niet in staat is zich zelve of zijne zaken te beheeren.

“Locale autoriteit” beteekent Landdrost, Ass. Landdrost, Resident Vrederechter, enz., of andere jurisdictie hebbende ambtenaren.

“Geneeskundige” beteekent een wettig bevoegde geneeskundige, in werkelijke praktijk, binnen de beteekenis van eenige nu of later van kracht zijnde wet.

“Gevangenis” beteekent eenige gevangenis of opsluitingsplaats, waarnaar een persoon mag worden verwezen, hetzij in

afwachting van voorloopig onderzoek of terechtstelling, veilige bewaring, straf of anderszins, onder eenige andere dan civiele procedure; en

“Gevangene” beteekent eenige aldus verwezen persoon.

2. De bepalingen van deze wet zullen toepasselijk zijn op iederen persoon die, bij het in werking treden er van, wettig aangehouden wordt in een gesticht of opsluitingsplaats voor krankzinnigen, en ieder bevelschrift of order toegestaan voor de aanhouding van zoodanigen persoon, zal geacht worden wettig te zijn uitgereikt, totdat het onder de voorzieningen dezer wet zal zijn opgeheven of veranderd.

3. Indien een konstabel overtuigd is dat het noodzakelijk is voor de publieke veiligheid of voor het welzijn van een beweerden krankzinnige ten opzichte van wien het zijn plicht is stappen te nemen onder deze wet, dat de beweerde krankzinnige, vóórdat zoodanige stappen worden genomen, onder zorg en contrôle behoort te worden geplaatst, dan mag de konstabel den beweerden krankzinnige aanhouden en vervoeren naar een gevangenis of hospitaal, en de cipier of opzichter van het hospitaal zal, tenzij er geen behoorlijke accommodatie in zoodanige gevangenis of hospitaal voor den beweerden krankzinnige is, den beweerden krankzinnige daarin ontvangen, overnemen en aanhouden, doch geen persoon zal aldus aangehouden worden voor langer dan acht-en-veertig uren zonder medeweten of machtiging van de locale autoriteit.

#### DEEL I.

##### *Handelwijze voor het bedwingen van gevaarlijke krankzinnigen.*

4. Wanneer iemand ontdekt wordt onder omstandigheden, die aanduiden verwarring van geest, en een voornemen om zelfmoord te plegen, of eenige misdaad of overtreding waarvoor zoodanige persoon zou kunnen vervolgd worden, dan zal eenige locale autoriteit ten overstaan van wien zoodanigen persoon wordt gebracht, waar mogelijk, de hulp inroepen van twee geneeskundigen (een waarvan, zoo doenlijk, de districts-geneesheer zal zijn), en zal zoodanige geneeskundigen en alle andere getuigen onder eede ondervragen. Indien het niet mogelijk is ter plaatse twee geneeskundigen voor dit doel te verkrijgen, dan zal één geneeskundige, zoo mogelijk de districts-geneesheer, voldoende zijn.

5. Indien de locale autoriteit, bij het zien en ondervragen van den aangehouden of te zijnen overstaan gebrachten persoon, en op de getuigenis van zoodanige geneeskundigen en anderen, overtuigd is dat die persoon een gevaarlijke krankzinnige is, en dat zijn geval niet behoorlijk kan worden behandeld onder de voorzieningen van Deel III van deze wet, dan mag hij door een order onder zijn handteekening gelasten dat zoodanige persoon zal worden gebracht naar en aangehouden in een hospitaal of andere plaats van veilige bewaring, totdat zoodanige persoon wettig zal worden ontslagen of overgebracht naar een gesticht op last van den Staatsprocureur.

6. Iedere locale autoriteit, indien men het hem onder eede doet blijken dat een vrij rondlopende persoon beschouwd wordt een gevaarlijke krankzinnige te zijn, mag door een order onder zijn handteekening eenigen konstabel verplichten zoodanigen persoon gevangen te nemen en te brengen ten overstaan van eenige locale autoriteit.

7. Iedere konstabel die een order van de locale autoriteit ontvangt, zal onmiddellijk handelen gelijk daarin wordt gelast, hetzij door zoodanigen daarin genoemden krankzinnige of veronderstelden krankzinnige gevangen te nemen of te vervoeren. En ieder die door een order van een locale autoriteit wordt gelast om zoodanigen krankzinnige of veronderstelden krankzinnige te ontvangen en aan te houden, zal handelen in gehoorzaamheid aan zoodanige order.

8. Indien te eeniger tijd na het toestaan van een order of bevelschrift voor de aanhouding van een persoon als een gevaarlijke krankzinnige, men het den Staatsprocureur doet blijken dat zoodanige persoon opgehouden heeft te zijn, of niet is, een gevaarlijke krankzinnige, en dat hij met veiligheid kan worden vrijgelaten, dan mag de Staatsprocureur het ontslag van zoodanigen persoon van bewaring gelasten, tenzij hij om een andere reden wettig wordt aangehouden.

9. De bepalingen van artikel negen-en-twintig tot en met artikel zeven-en-dertig van deze wet zullen zich respectievelijk uitstrekken tot en van toepassing zijn op iedere order voor het aanhouden van een gevaarlijke krankzinnige door een locale autoriteit, ingevolge dit gedeelte van deze wet uitgereikt.

## DEEL II.

### *Bepalingen met betrekking tot misdadige krankzinnigen.*

10. Wanneer in een akte van beschuldiging of ander crimineel proces eenige handeling of verzuim als een overtreding wordt ingebracht tegen eenig persoon, en bij de terechtstelling van zoodanigen persoon wegens die overtreding bewezen wordt dat hij krankzinnig was, zoo als niet volgens wet verantwoordelijk te zijn voor zijne daden ten tijde toen de handeling gedaan werd of het verzuim plaats vond, dan indien het komt te blijken aan de jury ten overstaan van wie zoodanige persoon terechtstaat, dat hij de hem ten laste gelegde handeling heeft gedaan of aan het verzuim schuldig is, doch als voorzegt krankzinnig was ten tijde toen hij dezelve deed of aan het verzuim schuldig was, dan zal de jury een speciale uitspraak of beslissing doen ten effecte dat de beschuldigde schuldig is aan de tegen hem ingebrachte handeling of verzuim, doch zooals voorzegt krankzinnig was ten tijde toen hij de handeling deed of het verzuim plaats vond.

11. Wanneer zulk een speciale uitspraak of beslissing wordt gedaan, dan zal het Hof een order geven omtrent de al of niet verdere bewaring in het gesticht van zulken persoon, eventueel voor hoelang als anderszins.

12. Wanneer het den Staatsprocureur komt te blijken dat een gevangene niet zijnde onder vonnis des doods, krankzinnig is, dan zal hij waar mogelijk twee, anders een geneeskundige (een waarvan, zoo doenlijk, de districtsgeneesheer zal zijn) gelasten zoodanigen persoon te ondervragen en naar zijn geestvermogens onderzoek te doen, en na zoodanige ondervraging en onderzoek zullen gezegde geneeskundigen in geschrifte certificeeren of hij krankzinnig is of niet.

13. Indien men het den Uitvoerenden Raad doet blijken, in het geval van een gevangene onder vonnis des doods, dat er reden is om te gelooven dat zoodanige gevangene krankzinnig is, dan zal de Uitvoerende Raad twee of meer geneeskundigen benoemen, die onmiddellijk zoodanigen gevangene zullen ondervragen en naar zijn geestvermogens onderzoek doen, en na zoodanige ondervraging en onderzoek zullen zoodanige geneeskundigen in geschrifte aan den Uitvoerenden Raad rapport doen omtrent de geestvermogens van den gevangene, en zij, of de meerderheid dier geneeskundigen zullen certificeeren of hij krankzinnig is of niet.

14. Wanneer een gevangene als voorzegt wordt gecertificeerd krankzinnig te zijn, dan mag in het geval, bedoeld in art. 12, de Staatsprocureur, en in het geval, bedoeld in art. 13, de Uitvoerende Raad, indien hij zulks goedvindt, gelasten dat zoodanige gevangene worde vervoerd naar het gesticht, en daarop zal zoodanige gevangene worden vervoerd naar en ontvangen in het gesticht, en zal, onderworpen aan de bepalingen van deze wet met betrekking tot ontslag en anderszins, daarin aangehouden worden als een misdadige krankzinnige, totdat hij ophoudt een misdadige krankzinnige te zijn.

15. Wanneer het door twee geneeskundigen wordt gecertificeerd dat een misdadige krankzinnige (niet zijnde een persoon met betrekking tot wien een speciale uitspraak of beslissing gedaan is dat hij schuldig was aan de tegen hem ingebrachte handeling of verzuim, doch krankzinnig was ten tijde toen hij de handeling deed of aan het verzuim schuldig was) gezond van zinnen is, dan mag de Staatsprocureur, indien overtuigd dat het passend is zulks te doen, door bevelschrift gelasten dat zoodanige persoon naar de gevangenis worde verwezen, om volgens wet mede behandeld te worden.

16. Het College van Curatoren van het Krankzinnigen-gesticht zal aan den Staatsprocureur rapport doen op zoodanige tijden (zijnde niet minder dan ééns per jaar) en bevattende zoodanige bijzonderheden als de Staatsprocureur moge vereischen, over den toestand en de omstandigheden van iederen misdadige krankzinnige in het gesticht; en de Staatsprocureur zal minstens éénmaal per jaar, gedurende hetwelk een misdadige krankzinnige wordt aangehouden, in overweging nemen den toestand, de geschiedenis en de omstandigheden van zoodanigen krankzinnige, ten einde te beslissen of hij behoort ontslagen of anderszins mede behandeld te worden.

17. De Staatsprocureur kan van tijd tot tijd gelasten dat eenige misdadige krankzinnige, aangehouden in een gesticht of andere plaats, worde overgebracht naar een ander gesticht en zoodanige misdadige krankzinnige zal dienovereenkomstig ontvangen en aangehouden worden in het gesticht, naar hetwelk hij aldus verwezen is.

18. De Uitvoerende Raad mag een misdadige krankzinnige onvoorwaardelijk ontslaan, of voorwaardelijk, dat is te zeggen, op zoodanige voorwaarden met betrekking tot den duur van zoodanig ontslag, en anderszins, als de Uitvoerende Raad moge gedenken.

19. Wanneer een misdadige krankzinnige krachtens deze wet voorwaardelijk wordt ontslagen zal:

- a. Een rapport over zijn toestand aan den Staatsprocureur worden gedaan door zoodanigen persoon, op zoodanige tijden, en bevattende zoodanige bijzonderheden als vereischt mogen worden door het bevel van ontslag, of gelast door den Uitvoerenden Raad, of door eenige algemeene regels en regulaties;
- b. Indien het den Uitvoerenden Raad toeschijnt dat eenige van de voorwaarden van zoodanig ontslag gebroken zijn, of het voorwaardelijk ontslag wordt herroepen, zal de Uitvoerende Raad mogen gelasten dat hij gevangen worde genomen en vervoerd naar het gesticht of een in het bevelschrift genoemde plaats; en hij mag daarop gevangen worden genomen en zal worden ontvangen en aangehouden in het gesticht of zoodanige plaats, al of hij daarheen was overgebracht onder de bepalingen van deze wet.

20. De Uitvoerende Raad mag regulaties opstellen, herroepen en veranderen voor de behandeling van tot gevangenisstraf veroordeelde personen die, overeenkomstig gezegde regulaties, wegens onnoozelheid schijnen te zijn hetzij ongeschikt voor tuchtiging of ongeschikt voor dezelfde tuchtiging als andere evangenen.

### DEEL III.

*Bepalingen met betrekking tot krankzinnigen die niet gevaarlijk noch misdadig zijn.*

21. Het College van Curatoren van het Krankzinnigen-gesticht zal gerechtigd zijn op eene applicatie van een of meer der betrekkingen of verzorgers van eenigen krankzinnigen persoon (welke applicatie door een locale autoriteit moet gesanctioneerd zijn), en bij overlegging van de certificaten van twee geneeskundigen, waarvan een zoo mogelijk de districts-geneesheer zal zijn (waar die niet te verkrijgen zullen zijn, zal het certificaat van één geneeskundige, namelijk van den districts-geneesheer, voldoende zijn), waarin ten genoegen van het College van Curatoren verklaard wordt dat zij den betrokken persoon onderzocht hebben en bevonden dat hij krankzinnig is, zulken persoon in het gesticht op te nemen.

22. Indien het den Landdrost of anderen jurisdictie hebbenden ambtenaar voor wien zulke applicatie zal gelegd worden, blijken moge dat een krankzinnig persoon geen familiebetrekking of verzorger binnen den Staat heeft, of geen die zonder ongelegen komend oponthoud te bereiken is, dan zal eenig genootschap of persoon onder wiens hoede of zorg zulke krankzinnige persoon zich dan tijdelijk bevinden moge, voor de doeleinden van het voorgaande artikel geacht worden de verzorger van dien krankzinnigen persoon te zijn: en het zal wettig zijn voor zulken Landdrost of ander jurisdictie hebbend ambtenaar om, te zijnen discretie, den applicant en eenig ander persoon, op eede te ondervragen met betrekking tot de feiten van eenig geval; en eenig daarbij gegeven moedwillig verkeerd antwoord van eenigen zulken applicant of ander persoon zal als meened beschouwd en volgens wet gestraft worden.

23. Iedere locale autoriteit mag, op informatie onder eede van eenigen persoon, dat een vrij ronddolende persoon beschouwd wordt een krankzinnige te zijn, per order een konstabel gelasten den beweerden krankzinnige gevangen te nemen en hem te zijnen overstaan te brengen, of ten overstaan van de locale autoriteit die jurisdictie heeft waar de beweerde krankzinnige zich bevindt.

24. Wanneer onder deze wet kennis is gegeven aan, of informatie onder eede is verschaft ten overstaan van een locale autoriteit, dat een vrij ronddolende persoon beschouwd wordt een krankzinnige te zijn, dan mag zoodanige locale autoriteit den beweerden krankzinnige aan diens eigen huis, of elders ondervragen, en mag in alle opzichten handelen alsof de beweerde krankzinnige ten overstaan van hem was gebracht.

25. Iedere konstabel die weet dat een niet vrij ronddolende persoon beschouwd wordt een krankzinnige te zijn en niet onder behoorlijke zorg en contrôle is, of wreed behandeld, of verwaarloosd wordt door eenigen nabestaande of anderen persoon die de zorg of bewaring van hem heeft, zal zonder verzuim informatie daarvan onder eede geven ten overstaan van de naastbijzijnde locale autoriteit.

26. Op de beëdigde verklaring of informatie onder eede van eenig iemand dat een persoon beschouwd wordt een krankzinnige te zijn, of dat zulk een persoon niet onder behoorlijke zorg, behandeling en contrôle is, of wreed behandeld of verwaarloosd wordt gelijk voorzegd, mag de locale autoriteit zelf den beweerden krankzinnige bezoeken, en zal, hetzij zoolanig bezoek wel dan niet wordt afgelegd, eenige twee geneeskundigen die hij goeddunkt (een waarvan, zoo doenlijk, de districts-geneesheer zal zijn), gelasten en machtigen den beweerden krankzinnige te bezoeken en te onderzoeken, en hun gevoelen van zijn verstandelijke vermogens te rapporteeren. In geval de diensten van twee geneeskundigen niet beschikbaar, of niet onmiddellijk beschikbaar zijn, mag de locale autoriteit één geneeskundige gelasten dien plicht te verrichten.



27. Indien op het rapport van den geneeskundige of de geneeskundigen die den beweerden krankzinnige hebben onderzocht, of na zoodanig verder of ander onderzoek als de locale autoriteit noodig mag oordeelen, hij overtuigd is dat de beweerde krankzinnige wel een krankzinnige en niet onder behoorlijke zorg, behandeling en contrôle is, of wrêd behandeld of verwaarloosd wordt door een nabestaande of anderen persoon die de zorg of bewaring van hem heeft, en dat hij een persoon is die behoort te worden in bewaring genomen en aangehouden onder zorg en behandeling, of indien de persoon die de zorg, behandeling van of contrôle over den beweerden krankzinnige heeft, toestemt in het uitreiken van de hierna in deze te melden order, dan mag de locale autoriteit door een order (in deze wet genaamd een sommiere order tot ontvangst) gelasten dat de krankzinnige worde ontvangen en aangehouden in het gesticht of andere plaats in zoodanige order te worden genoemd, en eenige konstabel wien de locale autoriteit moge gelasten zulks te doen zal den krankzinnige onmiddellijk vervoeren naar de plaats genoemd in de order.

28. Een sommiere order tot ontvangst zal de aanhouding van den daarin genoemden persoon machtigen voor een tijdperk van niet langer dan één maand.

29. Een locale autoriteit die zulk een order voor het aanhouden van een beweerden krankzinnige onder deze wet verleent zal zonder verzuim een kopie daarvan, met kopieën van de verklaringen en geneeskundige rapporten waarop hij handelde bij het toestaan van zoodanige order, en zijn eigen rapport opzenden aan den Staatsprocureur. De locale autoriteit zal ook binnen tien dagen gelijk voorzêgd opzenden het rapport van den districts-geneesheer, of van zoodanigen geneeskundige die den krankzinnige behandeld heeft, met betrekking tot diens toestand zoowel naar lichaam als van geest gedurende zijn aanhouding.

30. Niets in deze wet zal, in het geval van een krankzinnige met betrekking tot wien een sommiere order tot ontvangst gegeven is, een nabestaande of vriend verhinderen den krankzinnige onder zijn eigen zorg te behouden of te nemen, indien de locale autoriteit die jurisdictie heeft om de order te geven overtuigd is dat behoorlijke zorg zal worden genomen van den krankzinnige.

31. De Staatsprocureur zal ambtshalve *curator ad litem* zijn van zoodanige personen als aangehouden mogen worden onder een order door een locale autoriteit, volgens deze wet toegestaan, of verder aangehouden onder de order van eenen Rechter.

32. De Staatsprocureur zal bij ontvangst van een locale autoriteit van zoodanige order, verklaringen en rapporten als voorzêgd, binnen één maand dezelve tezamen met eenige verdere rapporten, verklaringen of verslagen die hij noodig heeft geacht om te vragen, aan een Rechter in Kamers voorleggen voor diens overweging.

33. De Rechter na het overwegen van zoodanige order, rapporten en daarin voorkomend bewijs van krankzinnigheid, mag gelasten als volgt:—

- a. Indien overtuigd dat een order voor de verdere aanhouding van den beweerden krankzinnige onmiddellijk kan worden gegeven, zoodanige order diensvolgens geven, en voor zoodanig tijdperk als hij noodig moge oordeelen.
- b. Gelasten dat een dagvaarding worde uitgegeven en betoekend op den beweerden krankzinnige en op den *curator ad litem*, om te verschijnen in het daarin te noemen Hof, ten einde redenen aan te toonen, waarom de beweerde krankzinnige niet verklaard zal worden krankzinnig te zijn, en een curator zal worden aangesteld voor de zorg van diens persoon, en zoo noodig voor de zorg of het beheer van diens goederen.
- c. Een *curator bonus* aanstellen voor de tijdelijke zorg of bewaring van enige goederen van den beweerden krankzinnige, en waar het den Rechter wenschelijk toeschijnt dat tijdelijke voorziening gemaakt worde voor het onderhoud of andere noodige doeleinden of vereischten van den beweerden krankzinnige, of eenig lid van diens familie, uit enige contanten of beschikbare securiteiten aan hem behoorende, in de handen van zijn bankiers of van eenigen anderen persoon, dan mag de Rechter zoodanigen bankier of anderen persoon machtigen aan den *curator bonus* te betalen zoodanige sommen als noodig mogen worden gecoördeld, en mag directies geven omtrent het aanwenden er van ten nutte van den beweerden krankzinnige of ter verlichting van diens familie.
- d. Gelasten dat de beweerde krankzinnige onmiddellijk worde ontslagen.
- e. Gelasten dat een dagvaarding of ander stuk worde uitgereikt en de procedure in de zaak worde voortgezet vrij van eenige zegelbelasting als anderszins en bevelen dat het beteekenen van eenige procedure onder dit artikel op zoodanige wijze geschiede als hij geschikt moge achten.
- f. Over het algemeen zoodanige directies geven, als noodig en passend mogen schijnen.

34. Van elke zoodanige order als bedoeld in het voorgaande artikel zal terstond afschrift worde gezonden aan het College van Curatoren van het Krankzinnigengesticht.

35. Niets dat in deze wet is vervat, zal den man, de vrouw, of anderen nabestaande van eenigen persoon die beschouwd wordt een krankzinnige te zijn, of den vriend van zoodanigen persoon die geen man, vrouw, of nabestaande heeft, in of nabij de plaats waar zoodanige persoon woonachtig is, beletten door petitie direct bij een Hof of Rechter aanzoek te doen om een

onderzoek naar de verstandelijke vermogens van zoodanigen persoon, hetzij een sommiere order tot ontvangst vroeger wel dan niet is toegestaan, en zoodanig Hof of Rechter mag daarin order geven naar dat passend zal geoordeeld worden.

36. Ieder die aangehouden wordt onder een order, volgens deze wet, van een locale autoriteit, of onder een order van een Rechter voor verdere aanhouding, toegestaan als voorzegd, mag, direct of door een *curator ad litem*, bij het Hof aanzoek doen, om een onderzoek naar de oorzaak en de redenen van de aanhouding van zoodanigen persoon, en zoodanig Hof mag daarin order geven naardat passend zal geoordeeld worden.

37. Wanneer een Rechter een order heeft toegestaan voor de verdere aanhouding van een krankzinnige, of wanneer een Hof een persoon krankzinnig heeft verklaard, dan mag de Staats-procureur per bevelschrift order zijn handteekening het overbrengen machtigen van zoodanigen krankzinnige naar het gesticht, een hospitaal of andere veilige opsluitingsplaats, om aldaar te worden gehouden tot dat hij wettig ontslagen of wettig naar een andere plaats overgebracht wordt.

#### DEEL IV.

##### *Bepalingen voor de zorg en het beheer van goederen van krankzinnigen.*

38. Het Hof mag een curator aanstellen voor de zorg en het beheer van de goederen van een persoon die krankzinnig is verklaard of van een persoon die wettig wordt aangehouden als misdadige krankzinnige of gevaarlijke krankzinnige, met of zonder borg-telling naardat het Hof moge gelasten en mag zoodanigen curator volmacht geven eenige gespecificeerde handeling te doen, of eenige gespecificeerde macht uit te oefenen, of mag een algemeene volmacht geven om ten behoeve van den krankzinnige, tot verdere order, alle of eenige van zoodanige machten uit te oefenen zonder verder aanzoek bij het Hof.

39. Wanneer het Hof na onderzoek van gevoelen is dat de persoon waarop het onderzoek betrekking had, zoo gekrenkt van hersenen is dat hij niet in staat is zijn zaken doch wel zichzelf te beheerschen, en niet gevaarlijk voor zichzelf of anderen is, dan mag zoodanig Hof zoodanige order geven als het goeddunkt voor de zorg of het beheer van de goederen vanden krankzinnige, met inbegrip van alle behoorlijke bepalingen voor diens onderhoud, doch het zal niet noodig zijn, tenzij het Hof goeddunkt zulks te doen, om eenige order te geven met betrekking tot de bewaring van diens persoon.

40. Wanneer een persoon die lid van een vennootschap is, door het Hof verklaard wordt een krankzinnige te zijn, dan mag het Hof door dezelfde order, of door een order later toegestaan, de vennootschap ontbinden.

41. Wanneer een Hof een order heeft toegestaan om een curator aan te stellen voor de zorg of het beheer van de goederen van een krankzinnige, dan zal een officieele kopie van zoodanige order onmiddelijk bij den Meester van het Hoog Gerechtshof worden ingediend.

42. De Meester zal zoodanigen curator een certificaat toestaan dat hij aldus aangesteld is, en als zoodanig gemachtigd is om de bewaring en het beheer te hebben van den boedel van den krankzinnige.

43. Iedere zoodanige curator zal onder dezelfde verplichting zijn als een executeur aangesteld voor het beheer van den boedel van een overledene, om bij gezegden Meester een inventaris, of additioneelen inventaris, van de goederen van een krankzinnige en rekeningen van zijne administratie in te leveren, en ten opzichte van zulk een inventaris of rekening zullen dezelfde zegels als anderszins betaalbaar zijn als in het geval van den boedel van een overledene.

44. Aan iederen zoodanigen curator zal worden toegestaan dezelfde belooning, te worden getaxeerd door gezegden Meester, als in het geval van een executeur.

45. Wanneer een krankzinnige voor de zorg of het beheer van wiens boedel een curator aangesteld is, zonder testament komt te sterven, of indien, een testament nagelaten zijnde, er geen executeur is of niemand die gewillig is om te ageeren, dan zal zoodanige curator voortgaan met het beheer van den boedel van zoodanigen krankzinnige en de baten er van uitdeelen alsof hij tot executeur-datief ware aangesteld.

46. Het Hof mag eenigen curator, benoemd als voorzegt, autoriseeren en gelasten om alle of eenige der volgende zaken te doen:—

- a. Goederen behoorende aan den krankzinnige te verkoopen;
- b. Goederen behoorende aan den krankzinnige, of waarin hij belanghebbende is, te ruilen of te deelen, en geld te geven of te ontvangen om de ruiling of deeling gelijk te maken;
- c. Eenigen handel of bezigheid van den krankzinnige voort te zetten of te staken;
- d. Huurcontracten van eenige goederen van den krankzinnige toe te staan;
- e. Eenig contract met betrekking tot de goederen van den krankzinnige aangegaan door den krankzinnige vóór diens krankzinnigheid uit te voeren;
- f. Eenige macht uit te oefenen of eenige toestemming vereischt voor het uitoefenen van eenige macht te geven, wanneer de macht gevestigd is in den krankzinnige voor diens eigen voordeel, of de macht van den aard is van een voordeelig belang in den krankzinnige;
- g. Geld op verband van de goederen van den krankzinnige te leenen voor de betaling van zijn schulden, of voor de betaling van eenige schuld of onkosten behoopen voor het onderhoud van den krankzinnige

of anderszins voor diens voordeel, of betaling van of voorziening voor de kosten van zijn toekomstig onderhoud;

- h. Geld aan te wenden voor of tot het onderhoud of het nut van den krankzinnige;
- i. Zoodanige rapporten met betrekking tot den boede van den krankzinnige te doen aan het Hof of aan den Meester, als zoodanig Hof zal goedvinden.

47. Niets dat in deze wet is vervat zal beschouwd worden de macht te beperken of te verkleinen die volgens wet door het Hof wordt bezeten met betrekking tot het verklaren dat personen gekrenkt van hersenen zijn, of om curatoren aan te stellen over den persoon of de goederen van een krankzinnige.

#### DEEL V.

##### *Overtredingen en straffen.*

48. Ieder die, behalve onder de bepalingen van deze wet, een krankzinnige of beweerden krankzinnige in een gesticht ontvangt of aanhoudt, of een krankzinnige of beweerden krankzinnige tegen betaling in bewaring neemt, kost en huisvesting verleent, of aanhoudt, zal schuldig bevonden zijnde, blootstaan aan een boete van niet meer dan vijftig pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan zes maanden.

49. Ieder die schuldig is aan eenige van de volgende daden of overtredingen zal, schuldig bevonden zijnde, blootstaan aan een boete van niet meer dan één honderd pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan twaalf maanden:

- a. Eene moedwillig valsche verklaring geeft van enig belangrijk feit in eenige petitie, aanzoek, opgaaf van bijzonderheden, rapport, of order tot ontvangst onder deze wet;
- b. Eene moedwillig valsche verklaring geeft van enig belangrijk feit in een geneeskundig certificaat, of ander certificaat, of in enig verslag van of rapport over den lichamelijken of verstandelijken toestand onder deze wet;
- c. Moedwillig in een boek, verslag, of opgave, eenige valsche aantekening doet omtrent eenige zaak ten opzichte waarvan hij door deze wet, of door regels of regulaties gemaakt onder deze wet, wordt vereischt aantekening te doen;
- d. Moedwillig eenige locale autoriteit, curator, *curator ad litem*, het College van Curatoren van het Gesticht, geneeskundige, konstabel, of anderen speciaal door de Regeering of onder een order van het Hof gemachtigden persoon, hindert in het uitoefenen van eenige der machten verleend door deze wet, of door eenige regels of regulaties gemaakt onder deze wet.

50. Iedere beambte, oppasser, wachter, dienstbode of andere persoon geëmployeerd in het gesticht of andere plaats, of ieder die de zorg of bewaring van een krankzinnige of beweerdten krankzinnige heeft, hetzij wegens een contract, of door de banden van bloedverwantschap, of huwelijk, of anderszins, die zulk een krankzinnige of beweerdten krankzinnige mishandelt of moedwillig verwaarloost, zal, schuldig bevonden zijnde, blootstaan aan eene boete van niet meer dan vijftig pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan zes maanden.

51. Iedere beambte, oppasser, wachter, dienstbode of andere persoon geëmployeerd in het gesticht of andere plaats die het ontvluchten of het gepoogde ontvluchten van een krankzinnige toelaat, of er aan behulpzaam is, of het oogluikend toelaat, of een krankzinnige verbergt, zal schuldig bevonden zijnde, blootstaan aan een boete van niet meer dan vijf-en-twintig pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan drie maanden; en aan onmiddellijk ontslag uit eenige betrekking die zoodanige schuldig bevonden persoon alsdan moge bekleeden.

52. Het zal niet geoorloofd zijn in het gesticht een manspersoon te employeeren bij de persoonlijke bewaring of bedwang van een vrouwelijke patient, en ieder die een manspersoon in strijd met dit artikel employeert, zal blootstaan aan een boete van niet meer dan vijf-en-twintig pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan drie maanden; met dien verstande dat dit artikel zich niet zal uitstrekken tot het verbieden van, of het opleggen van een boete wegens, het employeeren van manspersonen bij zulke gelegenheden van dringende noodzakelijkheid als volgens het oordeel van den eerstaanzeezenden ambtenaar van de inrichting zoodanig employeeren noodig maken, doch het employeeren zal aan het College van Curatoren van het Gesticht worden gerapporteerd.

53. Indien een beambte, oppasser, wachter, dienstbode of andere persoon geëmployeerd in het gesticht, of eenige persoon die de zorg of bewaring of oppassing heeft van een afzonderlijke patient, vleeschelijke gemeenschap heeft of poogt te hebben met eenige vrouw die onder zorg of bewaring als krankzinnige is, dan zal hij, schuldig bevonden zijnde, blootstaan aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan vijf jaren; en geen toestemming of beweerdte toestemming daartoe van zoodanige vrouw zal eenige verdediging zijn in een vervolging wegens zoodanige misdaad.

54. Ieder die eenige van de bepalingen van deze wet overtreedt, ten opzichte waarvan geen andere boete of straf door deze wet of door eenige wet anderszins is bepaald, of die eenige van de bepalingen van eenige door de Regeering onder deze wet gemaakte regels of regulaties overtreedt, zal, schuldig bevonden zijnde, blootstaan aan een boete van niet meer dan vijf-en-twintig pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan drie maanden.

DEEL VI.

*Alledri bepalingen.*

55. Onderhevig aan eenige in deze wet vermelde uitzondering, zal geen persoon, die niet een gevaarlijke krankzinnige, een misdadige krankzinnige, of een door een Hof verklaarde krankzinnige is, ontvangen of aangehouden worden in een geacht, hospitaal of andere plaats, of als een afzonderlijke patiënt, tenzij onder een order gegeven door een Hof of een Rechter.

56. Ieder die eenigen persoon als een krankzinnige in zijn huis ontvangt om kost en inwoning te verleenen, of hem voor betaling of waarde onder zijn zorg of bewaring neemt, zal, binnen vier-en-twintig uren na zoodanigen persoon aldus te ontvangen of te nemen, door de post een kennisgeving van zoodanige admissie zenden aan den Staatsprocureur met ware kopieën van de order, het verslag en de geneeskundige certificaten waarop zoodanige persoon aldus is ontvangen geworden.

57. De persoon die aldus zoodanigen krankzinnige ontvangt of hem in bewaring neemt, zal ook, na den tweeden, en voor den afloop van den tienden dag na zoodanige admissie, aan den Staatsprocureur opzenden een verslag, te worden geteekend door den geneeskundige die den krankzinnigen bezoekt, van diens verstandelijken toestand, en diens lichamelijke gezondheid en conditie.

58. Ieder zoodanige krankzinnige zal, zoo dikwijls als mag worden bepaald door de regulaties onder deze wet, of als mag worden gelast door den Staatsprocureur, bezocht worden door een geneeskundige die geen voordeel trekt uit, en die geen vennoot, vader, zoon, broeder, of ander bloedverwant heeft, die voordeel trekt uit de zorg en bewaring van zoodanigen krankzinnige.

59. Indien eenige bewoner of inwoner van een huis eenigen persoon als een krankzinnige daarin houdt of aanhoudt, behalve onder een order gemachtigd door deze wet, ofschoon hij een van zijn familie of een nabestaande is, langer dan den tijd van drie maanden nadat zijn krankzinnigheid gebleken is, en wanneer dezelve zoodanig is als om gedurende eenig gedeelte van zoodanigen tijd geweld of dwang te vereischen, dan zal zoodanige bewoner of inwoner, of de geneeskundige die zoodanigen persoon bezoekt, aan den Staatsprocureur zoodanige aanhouding bekend maken en zal aan den Staatsprocureur opzenden een certificaat, geteekend door ten minste een geneeskundige, omtrent den toestand van den aldus aangehouden persoon, en zal daarin melden de redenen (zoo er zijn) die het wenschelijk doen zijn dat zoodanige persoon onder private zorg blijft.

60. Indien de Staatsprocureur informatie of reden heeft om te gelooven of te vermoeden dat een krankzinnige, of een persoon behandeld als een krankzinnige, omtrent wiens toestand geen zoodanige kennisgeving, als voorzeggd, gedaan is, gehouden of aangehouden wordt of woonachtig is in eenig huis, en dat de krankzinnigheid van zoodanigen persoon drie maanden heeft

geduurd nadat dezelve gebleken is, en zoodanig is als om geweld of dwang te hebben vereischt, of indien zoodanige kennisgeving is gedaan als in het voorgaande artikel is bepaald, en de vermelde reden blijkt onvoldoende te zijn, en hij van gevoelen is dat onderzoek behoort te worden gedaan, dan mag hij gelasten dat zoodanig onderzoek zal worden gedaan als hij zal goedvinden.

61. Ieder geneeskundig certificaat of rapport onder deze wet zal geteekend zijn door een geneeskundige, en zal de feiten melden waarop de certificeerende geneeskundige zijn gevoelen heeft gegrond dat de beweerde krankzinnige krankzinnig is, onderscheidende feiten door hemzelven waargenomen van feiten door anderen medegedeeld; en geen order gegeven onder deze wet zal gegeven worden op een certificaat dat slechts op feiten door anderen medegedeeld gegrond is.

62. Ieder geneeskundig certificaat of rapport gegeven onder en voor de doeleinden van deze wet, zal bewijs zijn van de daarin voorkomende feiten in zoo verre als zij feiten zijn waarvan de persoon die het certificaat geeft zelf bewust is, en van het oordeel daarin gezegd te zijn gevormd door de certificeerende geneeskundigen op zoodanige feiten, alsof de daarin voorkomende zaken onder eede waren bevestigd geworden.

63. De geneeskundige certificaten of rapporten onder deze wet zullen niet worden ontvangen of opgehandeld indien dezelve gegeven zijn door iemand die aan den veronderstelden krankzinnige is verwant binnen den vierden graad van bloedverwantschap of verzwagering, of die de vennoot of assistent van een aldus verwanten persoon is; noch zal een van de personen die zoodanige certificaten of rapporten teekent aldus verwant zijn aan, of de vennoot of de assistent zijn van den ander.

64. Geen werktuigelijke middelen voor lichamelijk bedwang zullen op een krankzinnige worden angewend, tenzij het bedwang noodig is voor de doeleinden van heel- of geneeskundige behandeling, of om den krankzinnige te beletten zichzelf of anderen te bezeren; en voor zoover het gesticht betreft zal een volledig verslag van ieder geval van bedwang door werktuigelijke middelen van dag tot dag worden gehouden.

65. Iedere locale autoriteit, of persoon benoemd door een bevoegd Hof, of door de Regeering, om eenig onderzoek onder deze wet of ten opzichte van eenigen krankzinnige te doen, mag, indien hij het noodig oordeelt zulks te doen, eenigen persoon dagvaarden om ten overstaan van hem te verschijnen om onder eede te getuigen omtrent eenige zaak waarnaar zoodanige locale autoriteit of ander persoon, onder deze wet, of door eenige commissie of order uitgevaardigd door zoodanig Hof, of door de Regeering, gemachtigd is onderzoek te doen, welken eed zoodanige locale autoriteit of andere persoon mits deze gemachtigd wordt op te leggen.

66. Iedere persoon die niet overeenkomstig zulk een dagvaarding als in het laatstvoorgaande artikel is vermeld, verschijnt, of geene redelijke verontschuldiging voor zijn niet ver-



schijnen geeft, of die verschijnt en weigert om beeëdigd of onder vraagd te worden, zal, schuldig bevonden zijnde in het Hof van eenigen jurisdictie hebbenden locale autoriteit, blootstaan aan een boete van niet meer dan vijfen-twintig pond sterling, of aan gevangenisstraf, met of zonder harden arbeid, voor een tijdperk van niet langer dan drie maanden.

67. Iedere aldus als voorzeggd gedagvaarde persoon zal gerechtigd zijn om te worden betaald zijn onkosten alsof hij een getuige was gedagvaard om te verschijnen bij het verhoor van een crimineele zaak.

68. Eenig bevelschrift onder deze wet zal ten uitvoer gelegd worden door den persoon aan wien het gericht is, of door een konstabel, en wanneer het betrekking heeft op een persoon die niet in bewaring is, zal het ten uitvoer worden gelegd op dezelfde wijze alsof het een bevelschrift was voor het in hechtenis nemen van een persoon die van een overtreding beschuldigd wordt.

69. Indien iemand ontsnapt terwijl hij krachtens deze wet naar het gesticht of andere plaats wordt overgebracht, of indien eenige persoon die wetig aangehouden wordt in het gesticht of andere plaats voor krankzinnigen ontsnapt, dan mag hij weder teruggehaald worden door den eerstaanwezende ambtenaar van het gesticht, of eenigen daartoe behoorenden beambte of dienstbode, of door eenigen persoon die zoodanigen eerstaanwezende ambtenaar, beambte of dienstbode helpt, of door eenigen konstabel, en mag teruggebracht worden naar, en ontvangen en gehouden worden in het gesticht.

70. Eenige actie ingesteld door eenigen persoon die als een krankzinnige aangehouden was, tegen eenigeen voor enig iets onder deze wet gedaan, zal begonnen worden binnen de eerstvolgende drie maanden na het ontslag van den persoon die de actie instelt.

71. De Regeering mag van tijd tot tijd regels of regulaties maken en veranderen voor alle of eenige van de volgende doeleinden:—

- a. Voor het ontslag van krankzinnigen op het aanzoek van nabestaanden of vrienden, of op proeftijd;
- b. Voor het College van Curatoren van het Krankzinnigen-gesticht en met betrekking tot de rapporten aan of door hetzelfde te worden gedaan;
- c. Om de boeken voor te schrijven die in het gesticht of anderszins met betrekking tot een krankzinnige moeten worden gehouden, en de aantekeningen daarin te worden gedaan, en de rekeningen, opgaven, rapporten, uittreksels, kopieën, staten, kennisgevingen, documenten en informatie te worden gezonden aan de Regeering, den Staatsprocureur, of anderen persoon, of autoriteit, zooals de Regeering moge gelaten;
- d. Omtrent de personen door wie, de tijden wanneer, en de wijze waarop zoodanige aantekeningen, rekeningen, opgaven, rapporten, uittreksels, kopieën, staten

kennisgevingen, documenten en informatie moeten worden gedaan en gezonden, met betrekking tot eenig gesticht of eenigen krankzinnige of beveerden krankzinnige;

- e. Omtrent de voorwaarden van betaling en de accommodatie voor betalende patienten in het gesticht;
- f. Om voor te schrijven de vormen voor de doeleinden van deze wet, als bijvoeging tot, of in de plaats van, de vormen vermeld in de Schedule;
- g. Over het algemeen voor de behoorlijke administratie en het doeltreffend werken van deze wet, en de zorg en het gerief van krankzinnigen.

72. Onderworpen aan onder deze wet opgestelde regulaties mogen de vormen in de Schedule gebruikt worden, wanneer toepasselijk met zoodanige wijzigingen als de omstandigheden mogen vereischen, en zullen wanneer zij gebruikt worden, voldoende worden beschouwd.

73. Zoo veel van eenige andere wet als strijdig moge zijn tegen of onbestaanbaar met de bepalingen van deze wet, worden mits deze herroepen, doch deze herroeping zal geen invloed hebben op eenig bevelschrift uitgevaardigd, of op iets gedaan krachtens eenige zoodanige herroepen wet.

74. Aan allen, die zich mochten hebben blootgesteld aan eenige straf, actie of aan een in staat van beschuldiging gesteld worden, door het bewerken, orderen of in eenig opzicht betrokken te zijn geweest bij de zorg of verzekerde bewaring van personen, die, voordat deze wet zal in werking treden, op order van eenige autoriteit in verzekerde bewaring gesteld mochten zijn als gevaarlijke krankzinnigen of als beschuldigd zijnde van eenige misdad of misdrijf, zullen en worden hierbij kwijtscholden alle straffen, acties als anderszins welke mochten kunnen ontstaan zijn tengevolge van de in verzekerde bewaring stelling van zulke personen; en al zulke personen, welke op den datum dat deze wet zal in werking treden, zich in zulke verzekerde bewaring zullen bevinden, worden hierbij verklaard onderworpen te zijn aan de bepalingen dezer wet voor zover die van toepassing mogen zijn.

75. In alle gevallen waarin eenig persoon vóór de in werking treding dezer wet, op een certificaat, *bona fide* door een geneeskundige afgegeven, als krankzinnig in het gesticht mocht zijn opgenomen, zal tegen niemand eenigelei actie of vervolging kunnen worden ingesteld wegens die opname, alhoewel de geestvermogens van zulken persoon weder gezond mochten gewor'en zijn.

76. Voor de doeleinden der bepalingen dezer wet zal beschouwd en genomen worden dat het mannelijke het vrouwelijke, en het enkelvoudige het meervoudige insluit.

77. Deze wet treedt in werking op 1 Augustus 1894.

S. J. P. KRUGER,  
Staatspresident.

Gouvernementskantoor,  
Pretoria, 21 Juli 1894,

Dr. W. J. LEYDS,  
Staatssecretaris.

LUNACY ACT.

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No. 1—1897.]

[May 25, 1897.

# ACT

To Amend and add to the Law relating to Lunatics.

**B**E it enacted by the Governor of the Cape of Good Hope, with the advice and consent of the Legislative Council and House of Assembly thereof, as follows :—

Preamble.

1. "The Lunacy Act, 1891," and so much of any other law as may be repugnant to or inconsistent with the provisions of this Act are hereby repealed; but such repeal shall not affect any warrant issued or thing done in pursuance of any such repealed law.

Repeal of Laws.

2. In the construction of this Act the following terms shall have the meanings herein assigned to them unless there is something in the context repugnant to such construction :—

Interpretation of terms.

"Asylum" means an asylum for lunatics now existing or which may hereafter be declared by the Governor as an asylum or place for the reception or detention of lunatics.

"Court" means the Supreme Court of the Cape of Good Hope, and the Court of the Eastern Districts, the High Court of Griqualand, and any Circuit Court within the limits of the jurisdiction of such Courts respectively.

"Criminal Lunatic" means any person convicted of any crime and certified to be insane under the provisions of this Act.

"Governor's Pleasure Lunatic" means any person for whose detention during his pleasure the Governor is authorised to grant an order.

"Judge" means any judge of the Supreme Court.

"Constable" includes members of the police force, and field-cornets.

"Lunatic" includes any idiot or person of unsound mind incapable of managing himself or his affairs.

"Magistrate" means a resident magistrate, and includes an acting resident magistrate and an assistant resident magistrate.

"Medical Practitioner" means a legally qualified medical practitioner, within the meaning of any law now or hereafter in force.

"Prison" means any prison or place of confinement to which a person may be committed, whether on remand or for trial, safe custody, punishment or otherwise, under any other than civil process; and

"Prisoner" means any person so committed.

"Single patient" means any person detained as a lunatic by order under this Act in any place other than an asylum or prison as defined in this section.

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## LUNACY ACT.

No. 1—1897.

Act to apply to  
persons detained in  
asylum at time of  
taking effect thereof.

3. The provisions of this Act shall apply to every person who, at the taking effect thereof, is detained in an asylum or place of confinement for lunatics, and every warrant or order granted for the detention of any such person shall be deemed to have been legally granted until set aside or varied under the provisions of this Act: provided that insane unconvicted prisoners detained by warrant under the provisions of Act No. 20 of 1879 may, if the Governor think fit, and so order, cease to be classed as criminal lunatics and be thenceforth in the same position as if they had been dealt with as insane persons by summary reception order under Part I of this Act.

Urgency cases.

4. In cases of urgency where it is expedient either for the welfare of a person alleged to be a lunatic or for the public safety, that an alleged lunatic should be forthwith placed under care and treatment, he may be received and detained in any asylum or prison, upon an urgency order made (if possible) by the husband or wife or by a relative of the alleged lunatic, accompanied by one medical certificate, provided that

- (1) If an urgency order is not signed by the husband or wife, or by a relative of the alleged lunatic, the order shall contain a statement of the various reasons why the same is not so signed and of the connection with the alleged lunatic of the person signing the order, and the circumstances under which he signs the same.
- (2) No person shall sign an urgency order unless he is at least twenty-one years of age, and has, within two days before the date of the order, personally seen the alleged lunatic.
- (3) No alleged lunatic shall be received under an urgency order unless it appears from the medical certificate accompanying the order that the certifying medical practitioner has personally examined the alleged lunatic not more than three clear days before his reception.
- (4) The admission of an alleged lunatic on urgency order shall forthwith be notified by the person receiving the patient to the resident magistrate of the district, who shall thereupon on production to him of the urgency order and the medical certificate proceed in the same manner as if the original application had been made to him for the issue of a summary reception order.
- (5) An urgency order shall not remain in force for a longer period than seven days from its date.

## PART I.

## PROVISIONS RELATING TO LUNATICS WHO ARE NEITHER GOVERNOR'S PLEASURE NOR CRIMINAL LUNATICS.

Magistrate may  
order apprehension  
of person wander-  
ing at large and  
deemed to be a  
lunatic.

5. Any magistrate, upon the information on oath of any person, that a person wandering at large is deemed to be a lunatic, may by order require a constable to apprehend the alleged lunatic

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and bring him before the magistrate making the order, or before any magistrate having jurisdiction where the alleged lunatic is.

6. If a constable is satisfied that it is necessary for the public safety or the welfare of an alleged lunatic with regard to whom it is his duty to take any proceedings under this Act, that the alleged lunatic should, before any such proceedings are taken, be placed under care and control, the constable may apprehend and convey the alleged lunatic to a prison or hospital, and the gaoler or officer in charge of the hospital shall, unless there is no proper accommodation in such prison or hospital for the alleged lunatic, receive, relieve and detain the alleged lunatic therein, but no person shall be so detained for more than forty-eight hours without the knowledge and authority of a magistrate. It shall not be lawful to detain any alleged lunatic apprehended under this or any other section of this Act for a longer period than seven days without a magistrate's order under section ten unless a medical practitioner shall certify that it is impossible to decide as to the sanity or otherwise of the alleged lunatic within such period of seven days, in which case the magistrate may authorise the detention of the alleged lunatic for a further period not exceeding seven days.

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Constable may under certain circumstances remove alleged lunatic to prison or hospital.

7. When under this Act notice has been given to, or an information on oath laid before a magistrate, that a person wandering at large is deemed to be a lunatic, such magistrate may examine the alleged lunatic at his own house, or elsewhere, and may proceed in all respects as if the alleged lunatic had been brought before him.

Magistrate may examine such person.

8. Every constable who has knowledge that any person not wandering at large is deemed to be a lunatic, and either is not under proper care and control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, shall without delay give information thereof on oath before the nearest magistrate.

Constable to report to Magistrate cases of lunatics not under proper care, though not wandering about.

9. Upon the affidavit or information on oath of the husband or wife or other near relative of any person that such person is deemed to be a lunatic, or upon the affidavit or information on oath of any person that a person is deemed to be a lunatic and either is not under proper care, treatment and control, or is cruelly treated or neglected as aforesaid, any magistrate may himself visit the alleged lunatic, and shall, whether making such visit or not, obtain certificates from any two medical practitioners whom he thinks fit (one of whom shall, if practicable, be the district surgeon) as to the mental state of the alleged lunatic. In case the services of two medical practitioners shall not be available, or immediately available, the magistrate may accept the certificate of one medical practitioner.

Upon information given, magistrate may order person to be examined by medical practitioner.

10. If upon the certificate of the medical practitioners or practitioner who examined the alleged lunatic, and after such further or other enquiry as the magistrate thinks necessary, he is satisfied

Summary reception order. If magistrate satisfied that person is lunatic and not under proper care, he may order person to be detained.

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that the alleged lunatic is a lunatic, and either is not under proper care, treatment or control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, and that he is a proper person to be taken charge of and detained under care and treatment, or if the person having the care, treatment or control of the alleged lunatic consents to the issue of the order hereinafter mentioned, the magistrate may by order (in this Act termed a summary reception order) direct the lunatic to be received and detained in some asylum or other place to be named in such order. Provided that a summary reception order shall not be granted unless each medical practitioner on whose certificate it is proposed to grant such order has personally examined the alleged lunatic not more than fourteen clear days before the date of the summary reception order, and that it shall not be competent for a magistrate to accept, for the purposes of such order, the certificate of any Asylum Medical Officer or private medical practitioner to whose charge he proposes to commit the alleged lunatic by such order, or who has any interest in the payments to be made on account of such alleged lunatic; provided further that all proceedings under this and the preceding section with respect to alleged lunatics shall be conducted in private. And provided further that if at any time after the issue of such order, the magistrate having jurisdiction to make such order is satisfied that some relative or friend of the lunatic who is willing to take such lunatic under his own charge, will take proper care of such lunatic and provide for his maintenance, it shall be lawful for such magistrate, on the recommendation of the District Surgeon, notwithstanding anything to the contrary in this Act contained, to discharge such lunatic to the care and custody of such relative or friend.

Such order shall authorise detention for one month.

11. A summary reception order shall authorise the detention of the person named therein for a period not exceeding one month, and if the place named therein be not an asylum it shall be lawful for the magistrate who has issued such order at any time during its continuance to authorise by endorsement of such order the removal of the lunatic named therein from the place of detention specified therein to an asylum; provided that the magistrate shall notify such removal within twenty-four hours, to the *ex officio curator ad litem*; and provided further that after the removal of such lunatic to an asylum any regulations as to discharge, transfer or death of patients framed under the provisions of this Act shall apply to such persons so removed, and that notice of such discharge, transfer or death shall be given within twenty-four hours to the *ex officio curator ad litem*.

Magistrate granting such order to send copy of order, report and medical practitioner's report to the Attorney-General, Solicitor-General or Crown Prosecutor.

12. A magistrate granting any order for the detention of any alleged lunatic under this Act shall, without delay, transmit a copy thereof with copies of the depositions and medical reports upon which he acted in granting such order, and his own report, to the Attorney-General, or in case the lunatic shall have been committed

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to an asylum or place within the districts over which the Court of the Eastern Districts or the High Court of Griqualand respectively have jurisdiction, to the Solicitor-General, or the Crown Prosecutor as the case may be, and the Solicitor-General or the Crown Prosecutor as the case may be shall in such case be empowered to call for such further certificates or reports as he may deem necessary from any person whether or not such person shall reside within the districts over which the Court of the Eastern Districts, or the High Court of Griqualand respectively, have jurisdiction. The magistrate shall also within ten days transmit as aforesaid the report of the district surgeon or such medical practitioner as shall have been in attendance upon the lunatic, as to his mental condition during his detention, such report to be based upon an examination of the lunatic made not less than two or more than ten days after the date of the summary reception order; provided that if the lunatic shall have been committed by the order aforesaid to detention in an asylum, the duties of furnishing and transmitting the medical report shall devolve on the medical superintendent of such asylum. Such magistrate shall also make such report (if any) to the Colonial Secretary as may be prescribed by any general regulations, and otherwise conform thereto.

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13. The Attorney-General, and the Solicitor-General and Crown Prosecutor of Griqualand West, within the limits of the districts respectively in which the latter exercise their functions, shall be *ex officio curators ad litem* of such persons as may be detained under any order granted by a magistrate under this Act, or further detained under a judge's order.

The Attorney-General, Solicitor-General and Crown Prosecutor *ex officio* curators *ad litem* of such lunatics within their jurisdiction.

14. A *curator ad litem* receiving any such order, depositions and reports as aforesaid from a magistrate, shall, within the said period of one month, lay the same with any further reports, depositions, or statements which he may have deemed necessary to call for, before a judge in chambers for his consideration.

*Curator ad litem* receiving above reports, &c., to lay the same before Judge in Chambers.

15. The judge upon consideration of such order, reports, and evidence of lunacy therein appearing, may order as follows:—

The Judge may:—

- (1) If satisfied that an order for the further detention of the alleged lunatic may be made forthwith, make such order accordingly, and for such period as he may deem necessary.
- (2) Direct that a summons be issued and served upon the alleged lunatic and the *curator ad litem*, to appear in the court to be therein named to show cause why the alleged lunatic shall not be declared lunatic, and his detention as such confirmed, or if necessary a curator specially appointed for the care of his person, and for the care or administration of his property.
- (3) Appoint a *curator bonis* for the temporary care or custody of any property of the alleged lunatic, and where it appears to the judge desirable that temporary provision should be made for the maintenance or other necessary

Order further detention of alleged lunatic.

Call upon *curator ad litem* and lunatic to appear before an appointed Court.

Appoint a *curator bonis*.

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Direct discharge of alleged lunatic. Direct as to issue, service, &c., of summons.

Generally give necessary directions.

Husband, wife, friend, or relative of person deemed to be lunatic may apply directly to any Court or Judge for enquiry.

Any person detained under summary reception order may apply to Court for enquiry.

Where person is ordered to be further detained or is declared a lunatic, the Under Colonial Secretary may order his removal to Asylum.

Procedure if found insane prior to arraignment.

purposes or requirements of the alleged lunatic, or any member of his family, out of any cash or available securities belonging to him in the hands of his bankers or of any other person, the judge may authorise any such banker or other person to pay to the *curator bonis* such sums as may be deemed necessary, and may give directions as to the application thereof for the alleged lunatic's benefit, or the relief of his family.

(4) Direct that the alleged lunatic be immediately discharged.  
(5) Direct that any summons or other process be issued, and the proceedings in the case be continued, free of any stamp duty or office fee; and order that service of any process under this section be made in such manner as may seem expedient.

(6) Generally give such directions as may appear necessary and proper.

16. Nothing in this Act contained shall prevent any husband, wife, or other relative of any person deemed to be a lunatic, or any friend of such person who has no husband, wife, or near relative at or near the place where such person is residing, from applying by petition directly to any court or judge for an enquiry into such person's mental condition, whether a summary reception order shall previously have been granted or not, and such court or judge may order therein as may be deemed fitting.

17. Any person detained under the order of a magistrate under this Act, or under a judge's order for a further detention, granted as aforesaid, may apply to the court, directly or through a *curator ad litem*, for an enquiry into the cause and grounds of such person's detention, and such court may order therein as may be deemed fitting.

18. At any time after a magistrate has issued a summary reception order for the detention of a lunatic, or a court has declared a person a lunatic, the Under Colonial Secretary may by warrant under his hand authorise the removal of such lunatic to some asylum, hospital, or other safe place of confinement, there to be detained until legally discharged or legally removed to some other asylum or place, provided that in the case of a person dealt with by summary reception order, if such warrant of removal as aforesaid is issued prior to the grant of the judge's order, notice of the issue of the warrant shall forthwith be sent by the Under Colonial Secretary to the *ex officio curator ad litem*.

PART II.

PROVISIONS RELATING TO GOVERNOR'S PLEASURE AND CRIMINAL LUNATICS.

19. If at any time prior to the arraignment of any person against whom criminal proceedings have been initiated for some crime or offence it shall appear to the gaoler or other custodian of such person that such person is insane, such gaoler or other



custodian shall without delay report the fact to the magistrate of the district in which such person is confined; and such magistrate shall forthwith direct two medical practitioners or one medical practitioner if two are not immediately available, to examine such person and to enquire into his sanity, and after such examination the said medical practitioners may certify in writing that he is insane; and if upon such certificates or certificate the magistrate is satisfied that such person is a lunatic, the magistrate shall by order direct such person to be kept in custody in some prison pending the signification of the pleasure of the Governor: Provided that nothing in this or the next succeeding section shall be read as prohibiting the abandonment of the criminal charge at the discretion of the judge or magistrate concerned, and the adoption of the procedure specified in Part I of this Act in those cases in which the crime or offence charged is of a petty nature, and the interests of justice will not suffer by the abandonment of the charge.

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20. If on the arraignment or during the trial of any person charged with any crime or offence it shall appear to the presiding judge or magistrate that such person is insane, the question of such person's sanity shall be enquired into, by a jury especially empanelled for the purpose if the trial be before a judge, or otherwise by the magistrate before whom the trial is being held; and if such jury or magistrate shall find that such person is insane the presiding judge or magistrate shall record such verdict or finding and shall issue an order committing such person to some prison pending the signification of the Governor's pleasure.

Procedure if found  
insane during trial  
or on arraignment.

21. When in any indictment or other criminal proceedings any act or omission is charged against any person as an offence, and it is given in evidence on the trial of such person for that offence that he was insane so as not to be responsible according to law for his action at the time when the act was done or the omission made, then if it appears to the jury or magistrate before whom such person is tried that he did the act or made the omission charged but was insane as aforesaid at the time when he did or made the same, the jury or such magistrate shall return a special verdict or finding to the effect that the accused was guilty of the act or omission charged against him but was insane as aforesaid at the time when he did the act or made the omission; and the presiding judge or magistrate shall thereupon order the accused to be kept in custody in some prison pending the signification of the pleasure of the Governor.

Procedure when  
persons charged  
with offences are  
found to be insane  
by Jury or Magistrate.

22. When an order committing a person as aforesaid, pending the signification of the Governor's pleasure, has been granted, it shall be the duty of the keeper of the prison to which such person has been committed to send a copy of such order forthwith through the magistrate of the district to the Colonial Secretary for transmission to the Governor, and it shall be lawful for the Governor thereupon and from time to time to give such order for the safe

Such persons to  
be kept in custody  
during Governor's  
pleasure.

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If found after conviction to be insane.

custody of such person in such place and in such manner as the Governor may see fit.

23. When it shall appear to the superintendent of a convict station, to a gaoler, or to any other custodian of prisoners that a convicted prisoner in his charge is insane, such superintendent, gaoler, or custodian shall report the fact to the resident magistrate of the district in which such prisoner is confined; and such resident magistrate, on receipt of such report or on an order from the Colonial Secretary, shall forthwith direct two medical practitioners (one of whom shall, if practicable, be the district surgeon), to examine such prisoner and to enquire as to his sanity, and after such examination and enquiry, the said medical practitioners may certify, in writing, that he is insane, provided that unless the prisoner is under sentence of death, the magistrate may in case the services of two medical practitioners shall not be available, direct one medical practitioner, who shall be, if practicable, the district surgeon, to perform such duty.

Resident Magistrate to order him to be confined.

24. When a convicted prisoner is certified as aforesaid to be insane, the resident magistrate shall, by order under his hand, direct that the said prisoner be kept in custody in the prison in which he is confined, as a criminal lunatic, until the Colonial Secretary, or, if such prisoner be under sentence of death the Governor, shall, by warrant, issue directions as to his disposal. The magistrate issuing such order as aforesaid shall, without delay, transmit a copy of such order, together with copies of the medical certificates upon which he acted in granting such order, and of the criminal warrant under which such lunatic was detained in prison, to the Colonial Secretary.

If prisoner certified insane to be removed under warrant of Governor to some asylum, and detained there as a lunatic.

25. When a convicted prisoner not under sentence of death is certified as aforesaid to be insane the Colonial Secretary may, if he thinks fit, direct such prisoner to be removed to an asylum named in the warrant, and thereupon such prisoner shall be removed to and received in such asylum, and, subject to the provisions of this Act relating to discharge and otherwise, shall be detained therein, or in any other asylum to which he may be transferred as a criminal lunatic, until he ceases to be a criminal lunatic.

Procedure in case of prisoner under sentence of death.

26. When a prisoner under sentence of death is certified as aforesaid to be insane the Governor may, if he thinks fit, direct such prisoner to be removed to an asylum named in the warrant, and thereupon such prisoner shall be removed to and received in such asylum, and, subject to the provisions of this Act relating to discharge and otherwise, shall be detained therein, or in any other asylum to which he may be transferred as a criminal lunatic, until he ceases to be a criminal lunatic.

When it is certified that a criminal lunatic (other than one in respect to whom a special verdict was returned) is sane, the Colonial Secretary may order him to be remitted to prison.

27. When it is certified by two medical practitioners as aforesaid that a person being a criminal lunatic or Governor's pleasure lunatic (not being a person with respect to whom a special finding or verdict under section twenty-one of this Act has been returned) is sane, the Colonial Secretary, if satisfied that it is proper to do so,

may by warrant direct such person to be remitted to prison to be dealt with according to law.

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28. A criminal lunatic shall, upon the expiration of the sentence of imprisonment to which he may be subject, cease to be a criminal lunatic: provided, however, that the order or warrant under which he was previously detained as a criminal lunatic shall continue to operate as an authority for his detention pending the issue of the judge's order hereinafter mentioned. If one month before the expiration of his sentence of imprisonment a criminal lunatic is still of unsound mind, the asylum superintendent or other custodian of such lunatic shall forthwith transmit a medical certificate of insanity with such report and other documents as may be deemed necessary to the Attorney-General, Solicitor-General or Crown Prosecutor as the case may be, who shall without delay lay the same before a judge in chambers for his consideration: whereupon the said judge shall order the further detention of the said criminal lunatic as a case under Part I, or make such other order in accordance with section fifteen of this Act as the said judge may see fit; and such order shall have effect on and after the date of the expiration of the said lunatic's sentence of imprisonment.

When a criminal lunatic shall cease to be a criminal lunatic.

29. The superintendent of an asylum or other place in which a criminal lunatic or a Governor's pleasure lunatic is detained, shall make a report to the Colonial Secretary at such times (not being less than once a year), and containing such particulars as the Colonial Secretary may require, of the condition and circumstances of every criminal lunatic and Governor's pleasure lunatic in such asylum or place; and the Colonial Secretary shall at least once in every two years during which a criminal lunatic or Governor's pleasure lunatic is detained, take into consideration the condition, history and circumstances of such lunatic, for the purpose of determining whether he ought to be discharged or otherwise dealt with.

Superintendent of asylum or other place in which criminal or Governor's pleasure lunatic is detained, to report to Colonial Secretary at least once a year.

30. The Colonial Secretary may, from time to time, order the transfer of any criminal lunatic or Governor's pleasure lunatic detained in any asylum or other place, to any other asylum, and such criminal lunatic shall accordingly be received and detained in the asylum to which he is so transferred.

Colonial Secretary may order transfer of criminal lunatic or Governor's pleasure lunatic.

31. The Governor may discharge any criminal lunatic or Governor's pleasure lunatic absolutely, or conditionally, that is to say, on such conditions as to the duration of such discharge, and otherwise as the Governor may think fit.

Governor may discharge a criminal lunatic, absolutely or conditionally.

32. Where a criminal lunatic or Governor's pleasure lunatic is conditionally discharged in pursuance of this Act;

Conditions to be observed in conditional discharge.

- (1) A report of his condition shall be made to the Colonial Secretary by such persons and at such times and containing such particulars as may be required by the warrant of discharge (or directed by the Governor), or by any general rules and regulations;

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(2) If any of the conditions of such discharge appear to the Governor to be broken, or the conditional discharge is revoked, the Governor may direct him to be taken into custody, and removed to some asylum or place named in the warrant; and he may thereupon be taken, and shall be received and detained in such asylum or place as if he had been removed thereto under the provisions of this Act.

Governor may make regulations for dealing with prisoners who appear from imbecility to be unfit for penal discipline.

33. The Governor may make, revoke, and vary regulations for the treatment of persons sentenced to imprisonment who appear, in accordance with the said regulations, to be, from imbecility of mind, either unfit for penal discipline, or unfit for the same penal discipline as other prisoners.

### PART III.

#### PROVISIONS FOR THE CARE AND ADMINISTRATION OF LUNATIC'S PROPERTY.

Court may appoint curator over property of lunatic.

34. The court may appoint a curator for the care or administration of the property of any person declared lunatic, or of a person lawfully detained as a criminal lunatic or Governor's pleasure lunatic, with or without security, as the court may direct, and may confer upon such curator authority to do any specified act, or exercise any specified power, or may confer a general authority to exercise on behalf of the lunatic, until further order, all or any of such powers without further application to the court; provided that when a lunatic detained by order of a court or judge, but of whose property no curator has been appointed, possesses property the estimated value of which does not exceed five hundred pounds in respect of the corpus thereof or fifty pounds per annum in respect of the income thereof, a judge in chambers or the master of the supreme court may, on the application of the official *curator ad litem*, appoint a curator of the property of the lunatic.

Court may under certain circumstances appoint curator over property without appointing curator over person.

35. Where upon an enquiry the court shall be of opinion that the person to whom it relates is of unsound mind so as to be incapable of managing his affairs, but that he is capable of managing himself, and is not dangerous to himself or to others, such court may make such order as it thinks fit for the care or administration of the property of the lunatic, including all proper provisions for his maintenance, but it shall not be necessary, unless the court shall think proper to do so, to make any order as to the custody of his person.

Court may dissolve a partnership if member thereof declared a lunatic.

36. When any person being a member of a partnership is declared a lunatic by the court, the court may by the same order or by any order subsequently granted, dissolve the partnership.

Copy of order appointing curator over property to be lodged with Master.

37. When a court has granted an order for appointing a curator for the care or administration of the property of a lunatic, an office copy of such order shall forthwith be lodged with the Master of the Supreme Court.

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38. The Master shall grant to such curator a certificate that he has been so appointed, and is authorised as such to have the custody and administration of the lunatic's estate.

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Master to grant certificate of appointment to curator.

39. Every such curator shall be under the like duty and obligation as an executor appointed for the administration of the estate of a deceased person, to lodge with the said Master an inventory, or additional inventory, of the property of a lunatic and accounts of his administration, and in respect of any such inventory or account the like stamps and fees shall be payable as in the case of the estate of a deceased person.

Curator to file inventory, &c., with Master.

40. Every such curator shall be allowed the like remuneration, to be taxed by the said Master, as in the case of an executor.

Curator to be allowed same remuneration as executor.

41. When any lunatic for the care or administration of whose estate a curator has been appointed shall die intestate, or having left a will there shall be no executor, or none willing to act, such curator shall continue the administration of the estate of such lunatic, and distribute the assets thereof as if he had been appointed an executor dative.

If lunatic die intestate, or has no executor, curator bonis to act as executor.

42. The court may authorise and direct any curator appointed as aforesaid to do all or any of the following things :—

Court may authorise curator to do following acts.

- (1) Sell any property belonging to the lunatic.
- (2) Make exchange or partition of any property belonging to the lunatic, or in which he is interested, and give or receive any money for equality of exchange or partition.
- (3) Carry on or discontinue any trade or business of the lunatic.
- (4) Grant leases of any property of the lunatic.
- (5) Perform any contract relating to the property of the lunatic entered into by the lunatic before his lunacy.
- (6) Exercise any power or give any consent required for the exercise of any power where the power is vested in the lunatic for his own benefit, or the power is in the nature of a beneficial interest in the lunatic.
- (7) Raise money on mortgage of the lunatic's property for payment of his debts, or payment of any debt or expenditure incurred for the lunatic's maintenance or otherwise for his benefit, or payment of, or provision for, the expenses of his future maintenance.
- (8) Apply any money for or towards the maintenance or the benefit of the lunatic.
- (9) Make such reports concerning the lunatic's estate to the court or to the Master as such court shall deem fit.

43. Nothing in this Act contained shall be deemed to limit or abridge the power by law possessed by the court in regard to declaring persons of unsound mind, or to the appointment of curators to the person or property of any lunatic.

Act not to be taken to limit power of Court as to declaring persons insane, or appointing curators.

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PART IV.

OFFENCES AND PENALTIES.

Penalty for detaining alleged lunatic except under provisions of this Act.

44. Every person who, except under the provisions of this Act, receives or detains a lunatic, or alleged lunatic, in an asylum, or for payment takes charge of, receives to board and lodge, or detains a lunatic or alleged lunatic, shall, upon conviction, be liable to a penalty not exceeding fifty pounds.

Penalties for false statements, &c.

45. Every person guilty of any of the following acts or offences shall, upon conviction, be liable to a penalty not exceeding one hundred pounds, or to imprisonment, with or without hard labour, for any period not exceeding twelve months :—

- (1) Making any wilful misstatement of any material fact in any petition, application, statement of particulars, report, or reception order under this Act.
- (2) Making a wilful misstatement of any material fact in any medical certificate or other certificate, or in any statement or report of bodily or mental condition under this Act.
- (3) Knowingly making in any book, statement, or return, any false entry as to any matter as to which he is by this Act or by any rules or regulations made under this Act, required to make an entry.
- (4) Wilfully obstructing any magistrate, curator, *curator ad litem*, visitor, medical practitioner, constable, or other person specially authorised by the Governor, or under any order of court, in the exercise of any of the powers conferred by this Act, or by any rules or regulations made under this Act.

Penalty where no special penalty provided.

46. Every person who shall contravene any of the provisions of this Act in respect of which no other penalty or punishment is by this Act or by any law otherwise provided, or who shall contravene any of the provisions of any rules or regulations made by the Governor under this Act, shall, upon conviction, be liable to a penalty not exceeding twenty pounds, or to imprisonment with or without hard labour for any period not exceeding three months.

Penalty if nurse, &c., or persons in charge illtreat lunatic.

47. Any officer, nurse, attendant, servant, or other person employed in any asylum or other place, or any person having the care or charge of a lunatic, or alleged lunatic, whether by reason of any contract, or any tie of relationship, or marriage, or otherwise, who shall illtreat or wilfully neglect any such lunatic or alleged lunatic shall, upon conviction, be liable to a penalty not exceeding fifty pounds, or to imprisonment, with or without hard labour, for any period not exceeding six months.

Penalty for conniving at escape of lunatic.

48. Any officer, attendant, servant, or other person employed in any asylum or other place, who shall wilfully permit, or assist, or connive at the escape or attempted escape of any lunatic, or who shall secrete a lunatic, shall, upon conviction, be liable to a penalty not exceeding twenty pounds, and to instant dismissal from any position such convicted person may then occupy.

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49. It shall not be lawful to employ any male person in any asylum in the personal custody or restraint of any female patient, and any person employing a male person contrary to this section shall be liable to a penalty not exceeding twenty pounds: Provided that this section shall not extend to prohibit or impose a penalty on the employment of male persons on such occasions of urgency as may in the judgment of the superintendent of the institution render such employment necessary, but the employment shall be reported to the Colonial Secretary.

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Male person not to be employed in personal custody of female patient.

50. If any officer, attendant, or other person employed in any asylum, or any person having the care or charge of or attending upon any single patient, carnally knows, or attempts to have carnal knowledge of any female under care or treatment as a lunatic, he shall, upon conviction, be liable to imprisonment with or without hard labour for any period not exceeding five years; and no consent or alleged consent of such female thereto shall be a defence in any prosecution for such offence.

Penalty on person having charge of lunatic for carnally knowing female patient.

## PART V.

## GENERAL.

51. Whenever any person shall, with the previous consent of the Colonial Secretary, be brought into this Colony from any other Colony, State or Territory in South Africa, to which the Governor may by proclamation apply the provisions of this section, by virtue of a warrant under the hand of a person duly authorised in such Colony, State or Territory, to sign the same, setting forth that such person has been judicially declared in such Colony, State, or Territory to be a lunatic, such person shall within this Colony be deemed to be legally detained under such warrant for a period of one month from the date thereof, in any asylum or other safe place of confinement named in such warrant. On the admission of such person into the asylum or other safe place of confinement aforesaid, the medical superintendent or officer in charge of such asylum or other safe place of confinement shall forthwith forward the warrant with the supporting documents to the Attorney-General, Solicitor-General, or the Crown Prosecutor, as the case may be, for submission to a judge in chambers, and thereupon all the provisions of this Act shall apply as if such person were a person in respect of whom a summary reception order had been granted in terms of this Act.

Lunatics from neighbouring states and colonies.

52. Subject to any exception in this Act mentioned, it shall not be lawful to receive or detain in any asylum, hospital or other place, or as a single patient, any lunatic or alleged lunatic except under an order made by a magistrate, a judge or a court.

No person to be detained in asylum unless under order of Court or Judge.

53. Every person who shall take care or charge of any lunatic as a single patient, shall, within twenty-four hours after so taking charge of such person, transmit through the post a notice of such admission to the Colonial Secretary. True copies of the order,

Every person receiving a patient into his house to transmit a notice thereof to the Colonial Secretary.

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statement and medical certificates upon which such person shall have been so received shall be transmitted to the Colonial Secretary by the magistrate making the order.

Every such patient to be visited by independent medical practitioner.

54. Every such lunatic shall, as often as may be provided by regulations under this Act, or as may be directed by the Colonial Secretary, be visited by a medical practitioner not deriving, and not having a partner, father, son, brother or other relative who derives, any profit from the care and charge of such lunatic.

Insane person.

55. The Colonial Secretary may, on payment of such fee as he may prescribe and subject to such conditions and provisions as he shall deem fit, by writing under his hand grant to any person a licence to keep a house for the reception of more than one lunatic patient, and from time to time revoke or renew such licence.

Insanity of person residing in private dwelling house.

56. If the insanity of a person residing in a private dwelling with relatives or others, who receive no remuneration for his maintenance and care, has endured for a period of six months, and is of such a nature as to require compulsory confinement in the house, or restraint or coercion of any kind, the person who has charge of the patient shall intimate such detention to the Colonial Secretary and shall transmit to the Colonial Secretary a certificate signed by at least one medical practitioner as to the condition of the person so detained and the reasons (if any) which render it desirable that such person shall remain under private care. The Colonial Secretary may thereupon order that such person be so detained for a further period not exceeding six months, at the expiration of which period if the insanity still continues the necessary steps must be taken by the person having charge of the patient to obtain an order under section ten.

Insane person may be received to board and lodge in any private dwelling upon certificate.

57. A person suffering from insanity may be received to board and lodge and be taken charge of for payment in any private dwelling for a period not exceeding six months after his lunacy shall have become apparent, under a certificate granted by a duly qualified medical practitioner. No such lunatic or alleged lunatic shall be detained for a longer period than six months as above enacted unless under an order made by a magistrate or court or judge: Provided, however, that it shall be lawful for any magistrate on any report or information that any such lunatic is detained for improper purposes or is cruelly treated or neglected in any way, to visit such lunatic in the place where he is detained and make such investigation and enquiry as may be found necessary, and thereafter to take such proceedings as he may consider expedient.

Persons voluntarily submitting to treatment.

58. The medical superintendent of an asylum may, with the previous assent in writing of the Colonial Secretary, which assent shall not be given without written application by the patient, receive and lodge as a boarder, for the time specified in the assent, any person who is desirous of voluntarily submitting to treatment, but whose mental condition is not such as to justify the issue of certificates of insanity.



Provided always:

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- (a) That if such person makes a written application to the medical superintendent, he may be received as a boarder temporarily for a period not exceeding seven days, pending the receipt of the Colonial Secretary's assent.
- (b) That every such boarder shall be produced, if required, to the official visitors at their visits to the asylum.
- (c) That no such boarder shall be detained for more than three days after having given written notice to the medical superintendent of his intention or desire to leave, unless detained under an order made by a court or judge or resident magistrate.
- (d) That notices of admission, discharge and death with respect to all such boarders shall be made to the Under Colonial Secretary in the same manner as in the case of lunatics.
- (e) That every such boarder shall be discharged at the expiration of the time specified in the Colonial Secretary's assent, unless a renewed application is made and assent given.

59. Every medical certificate or report under this Act shall be signed by a medical practitioner, and shall state the facts upon which the certifying medical practitioner has formed his opinion that the alleged lunatic is a lunatic, distinguishing facts observed by himself from facts communicated by others; and no order made under this Act shall be made upon a certificate founded only upon facts communicated by others.

Requirements of medical certificates under Act.

60. Every medical certificate or report made under, and for purposes of this Act, shall be evidence of the facts therein appearing so far as they may be facts within the knowledge of the person making the certificate, and of the judgment therein stated to have been formed by the certifying medical practitioners on such facts, as if the matters therein appearing had been verified on oath.

Medical certificate evidence of certain facts.

61. The medical certificates or reports under this Act shall not be received or acted upon if made by any person related to the supposed lunatic within the fourth degree of consanguinity or affinity, or the partner or assistant of a person so related; and neither of the persons signing such certificates or reports shall be so related to, or the partner or the assistant of, the other of them.

Medical certificates not to be signed by person related to alleged lunatic within fourth degree.

62. Mechanical means of bodily restraint shall not be applied to any lunatic unless the restraint is necessary for the purposes of surgical or medical treatment, or to prevent the lunatic from injuring himself or others; and in every such case

Under what circumstances mechanical means of bodily restraint allowed.

- (1) A medical certificate shall, as soon as it can be obtained, be signed, describing the mechanical means used, and stating the ground upon which the certificate is founded.
- (2) The certificate shall be signed, in the case of a lunatic in an asylum or other place of confinement, by the medical officer thereof, and in the case of a private patient, by his medical attendant.

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- (3) A full record of every case of restraint by mechanical means shall be kept from day to day.
- (4) A copy of the certificates and records under this section shall be sent to the Colonial Secretary at the end of every quarter.
- (5) In the application of this section "mechanical means" shall be such instruments as the Governor may, by regulations, determine.

Any person appointed under this Act to make enquiry may examine on oath and summon witnesses.

63. Any magistrate, or any commissioner, or person appointed by any competent court, or by the Governor, to make any enquiry under this Act, or in respect of any lunatic, may, if he deems it necessary so to do, summon any person to appear before him to testify on oath touching any matter respecting which such magistrate, commissioner or other person is under this Act, or by any commission or order issued by any such court, or by the Governor, authorised to enquire (which oath such magistrate, commissioner or other person is hereby empowered to administer).

Penalty for not obeying such summons.

64. Every person who does not appear pursuant to any such summons as is in the last section mentioned, or does not assign some reasonable excuse for not appearing, or who appears and refuses to be sworn or examined, shall, on conviction in the court of any resident magistrate having jurisdiction, be liable to a penalty not exceeding twenty pounds.

Expenses of witnesses.

65. Every person so summoned as aforesaid shall be entitled to be paid his expenses as if a witness summoned to attend upon a trial in a criminal case.

Requirements and execution of warrant under this Act.

66. A warrant of the Governor under this Act may be under the hand of the Colonial Secretary or of the Under Colonial Secretary, and where any warrant is authorised or required to be granted by the Colonial Secretary, such warrant may be under the hand of the Under Colonial Secretary. Every such warrant and every magistrate's order for the detention or removal of a lunatic may be executed by the person to whom it is addressed, or by any constable, and when it relates to a person not in custody may be executed in like manner as if it were a warrant for the arrest of a person charged with an offence, and it shall be the duty of every constable to aid in the execution of every warrant under this Act.

Powers of Colonial Secretary under Act may be exercised by another person appointed by Governor.

67. The Governor may, from time to time, direct that all or any of the powers, duties and authorities by this Act vested in or required to be performed by the Colonial Secretary, shall be exercised and performed by any person the Governor shall think fit, subject to any restrictions or limitations he may impose, or that such powers, duties, and authorities may, as to certain parts of the Colony, be exercised by the Colonial Secretary, and as to certain other parts by some person or persons other than the Colonial Secretary.

Escaped lunatic may be recaptured.

68. If any person escapes while being conveyed to an asylum or place in pursuance of this Act, or if any person lawfully detained

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in an asylum or other place for lunatics escapes, he may be retaken within twenty-eight days after his escape by the superintendent of such asylum, or person in charge of such other place, or any officer or servant belonging thereto, or by any person assisting such superintendent, person in charge, officer or servant, or by the duly appointed escort of such escaped person, or by any constable, and conveyed to and received and detained in such asylum or other place. If not retaken within twenty-eight days he shall be formally discharged, and before re-admission a new order must be obtained; provided that in the case of any criminal or Governor's pleasure lunatic who escapes he may be recaptured as aforesaid at any time after escape.

No. 1. 1897.

69. When any person shall be detained under the provisions of this Act in any asylum, or other place, the maintenance of such person shall, until further provision therefor be made, be defrayed out of the Colonial revenues: Provided always that all sums so paid may be recovered from the estate of any such person, or from any person or persons liable by law to contribute towards the maintenance of such detained person, by the civil commissioner of the district in which such estate is situated, or in which the person or persons so liable shall reside.

Cost of maintenance in an asylum or other place.

70. If the port health officer at any port in this Colony certifies to the resident magistrate of the district in which such port is situate within sixty days after the arrival of any vessel that a passenger or seaman arriving by such vessel is insane, imbecile or idiotic, and has become or is likely to become a charge upon the public as an inmate of an asylum or other place for the reception of the insane, it shall be lawful for the said resident magistrate thereupon to require the owner, charterer, agent or master of the said vessel to execute with two sufficient sureties jointly and severally a bond in such sum as the said resident magistrate may determine, not exceeding five hundred pounds sterling, conditioned to pay to the said resident magistrate the maintenance of such passenger or seaman in such asylum or other place for the detention of lunatics at such rates and for such term as may be determined by the said resident magistrate, or at the option of such owner, charterer, agent or master, subject to the approval of the resident magistrate, to return such passenger or seaman to the place whence he was shipped.

Procedure when persons on board ship become insane.

71. The sureties shall prove to the satisfaction of the resident magistrate that they are respectively resident within this Colony and worth treble the amount of the bond over and above all the liabilities: Provided that no bond shall be required when the passenger or seaman is at the date of the arrival of the vessel domiciled in this Colony; but the onus of proving such domicile shall be upon the said owner, charterer, agent or master.

Sureties to be resident in this Colony.

72. If the said owner, charterer, agent or master neglects or refuses to execute the bond as aforesaid within seven days after being so required, he shall be liable to a penalty not exceeding

Penalty for neglecting or refusing to execute bond.

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- No. 1—1897. £500 to be recovered summarily before the resident magistrate of the district in which the port is, and the said vessel shall not be cleared out until the bond is executed as aforesaid.
- Action by lunatic, limitation of. 73. Any action brought by any person who has been detained as a lunatic against any person for anything done under this Act shall be commenced within three months next after the release of the person bringing the action.
- Appointment of visitors. 74. It shall be lawful for the Governor from time to time to appoint fit and proper persons to visit, inspect and report on asylums and licensed houses under the provisions of this Act.
- Governor may make, &c., regulations. 75. The Governor may, from time to time, make and alter rules or regulations for all or any of the following purposes:—
- (1) For the discharge of lunatics on recovery or on the application of relatives or friends, or on probation.
  - (2) For the removal or transfer of lunatics from one asylum or place to another asylum or place, including the temporary transfer of patients to any specified place for such period as may be deemed expedient, for the benefit of their health.
  - (3) For the guidance of visitors and as to the reports to be made to or by them.
  - (4) For prescribing the books to be kept in asylums or otherwise in reference to any lunatic, and the entries to be made therein, and the accounts, returns, reports, extracts, copies, statements, notices, documents and information to be sent to the Colonial Secretary, or other authority or person as the Governor may direct.
  - (5) As to the persons by whom, the times when, and the manner in which such entries, accounts, returns, reports, extracts, copies, statements, notices, documents and information are to be made and sent, in regard to any asylum, or any lunatic or alleged lunatic.
  - (6) As to the terms of payment and accommodation for paying patients in any asylum.
  - (7) For the management of licensed houses.
  - (8) For prescribing forms for the purposes of this Act.
  - (9) Generally for the due administration and efficient working of this Act, and the care and comfort of lunatics.
- Idiots from birth or early age may be detained. 76. Notwithstanding anything to the contrary in this Act an idiot or imbecile from birth or from an early age may, if under age, be placed by his parents or guardians or by any person undertaking and performing towards him the duty of a parent or guardian, and may lawfully be received into, and until of full age detained in such institution as the Colonial Secretary may appoint, for the care, education and training of idiots or imbeciles, upon the certificate in writing of a duly qualified medical practitioner that the person to whom such certificate relates is an idiot or imbecile capable of receiving benefit from training in such institution, accompanied by an application to the Colonial Secretary

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signed by the parent or guardian or person acting as such, and a statement by a resident magistrate in accordance with regulations framed under the provisions of this Act: Provided that the consent of the Colonial Secretary for the further detention of the above idiot or imbecile shall be obtained within one month of his reception into such institution; failing which the said idiot or imbecile shall be discharged.

No. 2-1897.

77. The Governor may from time to time make and alter rules and regulations: Governor may make and alter regulations.

- (1) For prescribing the books to be kept and the entries to be made in reference to any idiot or imbecile, and the returns, reports, extracts, copies, statements, notices, documents and information to be sent to the Colonial Secretary or other authority or person as the Governor may direct.
- (2) For prescribing forms for the purposes of the last preceding section.
- (3) Generally for the due administration and efficient working of such institution and the care and comfort of idiots or imbeciles.

78. This Act may be cited for all purposes as the "Lunacy Act, 1897," and shall take effect from a date to be fixed by the Governor by proclamation. Short Title.

Appendix to Chapter VIIIThe Eugenics Movement in the United States 1920s - 1930s.

In America, particularly in the state of Virginia, the eugenics policy was practised on an immense scale, principally at the Lynchburg Colony, an institution set up in 1910, originally for the care of epileptics, but soon to encompass the feeble-minded, physically disabled and poor whites described as "socially inadequate". Crockett (1995)

Quoting from records of the Lynchburg Colony, Dr. Paul Lombardo, an historian at the University of Virginia, asserts that a large, but unspecified number of enforced sterilisations were illegally performed privately on inmates of both gender at Lynchburg by the Medical Superintendent, Dr. A. S. Priddy, between 1910 and 1917. Lombardo (1995).

Crocket (1995), confirms that Priddy was sterilising patients on the grounds of their supposed moral delinquency from 1910 until 1917 when a patient successfully sued Priddy for illegal sterilisation. Although Crockett states that the unlawful operations at Lynchburg apparently ceased following the law-suit, it would appear that Priddy continued to look for a loop-hole in the law and in 1924 he brought a test case to court.

The defendant was the daughter of an allegedly feeble-minded mother, from whose custody she had been removed, and was in the care of foster parents. Although her school records, later located by Lombardo, attest to above average results, the girl was described in court as feeble-minded.

## II

The deciding factor in the application to bring the case to court was the fact that the girl had given birth to an illegitimate baby. This child was the result of the girl being raped by the son of her foster parents, a fact which they, and the court, refused to acknowledge. The foster parents claimed the girl was "morally delinquent". Their claim was accepted by the court and the girl brought before a judge as a test case.

Priddy, as plaintiff, pleaded for a change in Virginia law to allow sterilisation of this girl and those like her who, themselves regarded as feeble-minded, gave birth to illegitimate children. The defence called into court a social worker who described the child conceived from the rape as "looking peculiar". The baby was then six months old. The defence pleaded their case; that the girl was the feeble-minded daughter of a feeble-minded mother, and had herself produced a feeble-minded child.

Lombardo (1995) asserts that records show that the presiding judge, Justice Oliver Wendall Holmes and the defending counsel were both known to be supporters of the eugenics policy. Not surprisingly therefore Priddy won his test case, with Justice Holmes stating that:

"the principal that sustains compulsory vaccination was broad enough to cover cutting the Fallopian tubes of women with heredity defects. Three generations of imbeciles was enough."

In the years following this judgement the number of sterilisations throughout the United States increased. A total of 8,300 enforced sterilisations were recorded in Virginia,

### III

the majority at Lynchburg, between 1910 - 1917 (when halted by law) and 1924 - 1973 (following the Priddy case). The subjects of these operations were said to be physically handicapped; epileptic; feeble-minded or poor white teenagers judged socially inadequate because of minor thefts, absconding from foster homes, or in the case of girls, becoming pregnant with an illegitimate child, even as a result of rape. The total number of such operations in the United States for that period was 70,000. Lombardo (1995)

In the 1930s. Dr.J.S.Jarnette of Virginia projected a saving to the state of \$370,800,000 over the course of 100 years as a result of 3,091 sterilisations. Crockett (1995) It would be reasonable to assume that such an estimate would be sufficient to influence both politicians and the public at large in favour of the policy of eugenics.

Once again economics and politics appear to have dominated over human rights, although Crockett (1995) asserts that a few dissenting voices were raised in America. One of these was a Hollywood producer, unnamed, who made a stance by bringing the question of enforced sterilisation of the "socially inadequate" to public notice. Crockett (1995) uses the example of an unspecified film company in Hollywood who produced a film entitled "Tomorrow's Children". This cites two instances;

- a) a girl of apparently normal intelligence being told by social workers that she, and her entire family, must be sterilised because one brother is crippled and two other siblings are "not very bright".



#### IV

- b) a girl being refused permission to marry on the grounds that her elder brother is in gaol, another brother is a cripple, and two other siblings are feeble-minded. Despite a doctor's assertion that the girl is "sound" she is refused a marriage licence on the grounds that she may produce "unfit" children. The presiding judge quotes, almost verbatim, the words used by Justice Oliver Wendall Holmes in the factual trial of Priddy versus Buck previously mentioned, "Three generations of unfit are enough." (It is not stated in the film clip presented by Crockett why there are three generations in this case.)

Nowhere among legal or political documents were Crockett or Lombardo able to detect evidence of human rights being considered. Given the background of the Depression it was highly unlikely that any American politician would contest a bill, passed in 1927 designed to save his constituents millions of dollars.

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